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EDITORIAL

Termination and Good-bye: 
The Transfer of Editorial Skills 
to Group Practice

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As I sit here trying to write my last editorial 
as editor of The Journal for Specialists in 
Group Work, I can’t believe that it has been 6 
years since I took over as editor. But I guess 
it has been, since I now have a 2- and a 5-
year-old that I didn’t have when I started as 
editor. So as I think about what I would like to 
say, what comes to mind is what my students 
would say about me if you asked them how I 
prepare them for termination from their 
groups in practicum. They would probably say, 
“She makes us do it and process it to death.” 
Now, if I questioned them further, they would 
hopefully recite a series of questions to guide 
the termination process of a group: What have 
I learned? How have I learned what I have 
learned? Who do I need to thank for helping me learn what I have 
learned? And most important, what am I going to do differently as a 
result of this experience? And so I guess I have to practice what I preach. 
I will use my questions as a framework for my editorial today. And in the 
fashion of effective group terminations, I am going to try to transfer my 
editorial skills to group work practice.

Before I start with my answers, I’d like to say that I have mixed emo-
tions over ending my term as editor. Although there is some relief in 
being able to spend more time on my own writing and research and, I 
hope, leading groups (and maybe even spending a few more hours with my 
family), there is also much regret. The regret comes from the sense that I 
will be missing seeing what is happening on the cutting edge in the field 
of group work. What are the latest research findings? What are the most
effective interventions? What are new ways of teaching group-work skills? Certainly, what makes this termination easier is that I know that Don Ward and Maria Riva will be great as editors. Knowing this makes it so much easier to hand over the reins of the journal when I know that it will be in competent hands.

What Have I Learned as a Result of Being Editor?

Well, the easy answer to that question is all the information I’ve learned about group work in terms of new approaches to group work, theories, information on the processes that make groups effective. I got to read the most current theory, research, and practice about group work just about every day, and that was incredibly exciting for me. It was also very helpful in helping me formulate what my next research questions will be. I’d like to share some of them with you as well as a summary of what I’ve learned. At this point, I think that we can safely conclude that groups are more effective than no treatment at all. So it is time to stop asking the question, Do groups work? and turn to the question of effective processes and interventions. What is it about the groups that make them effective? Is it the therapeutic factors? Is it specific interventions? Are the effective processes different for different types of groups? Different group members? Dennis Kivlighan’s work has helped us to recognize that the therapeutic factors in group work are different from therapeutic factors in individual counseling. Therefore, we needed to take that process a step further on Gordon Paul’s (1966) question about what treatment for what person with what problem extends to group work, in that we need to think about when group work is most useful. If we assume that almost all problems are interpersonal in nature, then most of the time group work is going to be effective. The next question is then what we need to do in the group, specifically what kinds of activities and interventions are needed so that group members learn what they need to learn? And what needs to happen so that group members not only learn new skills but that they then can transfer them outside of group to their other relationships?

The harder answer to this question relates to interpersonal skills. I have learned so much that is applicable to group work skills. First, I think, more than anything I have learned about multiple realities. Everyone has their own sense of what is happening, and in the editing process, similar to in a group, people must communicate what they want clearly and then check to make sure that the other person(s) heard and understood the intended message. I often thought I was being clear about what I wanted in terms of editorial changes only to realize that the
author(s) had heard something very different. This process of affirming
that people hear things differently is important because oftentimes, as
group leaders, we assume that people don’t do what we asked them to do
because they are resistant. Sometimes they aren’t being resistant; they
just heard a different message than the one you meant to convey.

I also learned some important information about feedback. First, it is
essential to tell people what they are doing that works so that they will
continue to do it. In the editorial process, it is important to begin each
review with the strengths of the manuscript so that these strengths
remain in future drafts. It is important to identify and acknowledge
strengths and things that work so that they don’t disappear as people
struggle to make changes. In a group setting, it is important to acknowledge
what behaviors are helpful and contribute to the group process so
that members know what works and is helpful.

Second, and probably more important, it is important to give positive
feedback before constructive feedback. Authors need to be acknowledged
in terms of the contributions of their manuscript before they can hear
what needs to be changed. If one begins with change this and that,
it is hard to believe that their manuscript has been seen as worthwhile
or valued. As a group member, a person needs to hear what they are
doing that works and is helpful before they can think about changes
they might want to make in their behavior. The balance of positive and
constructive feedback makes it easier for authors and group members to
view the feedback as realistic and useful as it acknowledges both
strengths and weaknesses.

I also learned the very important lesson that everyone won’t like you
(or what you do) all of the time. And this seems like such an important
lesson for group leaders. It is hard to be the leader, the rule enforcer, the
person who asks tough questions, who challenges group members to try
out new behaviors, and who provides constructive feedback when it is
difficult to hear. I often tell beginning group leaders that although the
feedback of group members is important, evaluative comments from
supervisors, peers, and yourself are more realistic in that these sources
have a better sense of what needs to happen in groups to help people
learn, change, and grow. Group members may like you but they might
not get anything out of group if you don’t challenge them. It was the
same for journal editorship. People would like me better if more manu-
scripts had been accepted (and accepted with fewer revisions), but the
usefulness of the journal to our readers might have been compromised.
In the end, the journal was more important to me than people liking me.
And that’s a tough but good lesson to learn. Albert Ellis would be proud.
Who Do I Need to Thank for Helping Me Learn What I Have Learned?

First of all, I need to thank all the authors who considered our journal as a place to publish their work. I learned so much about group work and how to write in general from them. Second, I need to thank my editorial board who taught me so much about writing, research design, statistical analyses, and group theory and practice. Most important, I learned from them how to give tactful, constructive, and useful feedback. Next, I need to think Don Ward who made my life easier when he became the associate editor by being a pillar of support, a major contributor to the editorial process, and a quick study to the editorship. Last, I need to thank the Association for Specialists in Group Work Executive Board over the years for their financial and emotional support, particularly Bob Conyne, Andy Horne, Sam Gladding, Bev Brown, Michael Hutchins, Jerry Donigian, Carolyn Thomas, and Lynn Rapin.

Thanks again to all of you who helped me through this incredible journey.

REFERENCE

Countertransference in the Development of Graduate Student Group Counselors: Recommendations for Training

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Teaching beginning group counselors to become aware of countertransference and understand the application of this to practice is an area that has not received much attention. This article presents a discussion of the phenomenon of countertransference in group work and provides recommendations about how to incorporate countertransference as a key aspect of training in group therapy.

During the past decade, there have been concerns raised about graduate-level training for group counselors. Criticism has been directed at graduate programs for not offering extensive clinical experience recommended by the Association for Specialists in Group Work (Conyne, Wilson, Kline, Morran, & Ward, 1993; Wiggins & Carroll, 1993). The Council for Accreditation of Counseling and Related Educational Programs (1994) requires a minimum of 10 practicum hours in group work, whereas the Association for Specialists in Group Work (2000) proposes a minimum of 45 clock hours of supervised practice (60 hours is strongly recommended). Even so, most graduate counseling programs neglect or underemphasize this requirement, with less than half of the programs offering a formalized group practicum (Hetzel, Stockton, & McDonnell, 1994). Research has shown that most graduate faculty feel that the training opportunities for counseling students to
become proficient group counselors are limited, or even nonexistent (Conyne, et al., 1993; Wiggins & Carroll, 1993).

Few would deny Corey's caveat to the profession that if proficient group leaders are to emerge, counselor education programs must make group work a priority. Even so, in many graduate programs there is no required group counseling course, whereas in others a group counseling course is only an elective (G. Corey, 2000). Even when group work is emphasized within a graduate program, it is not surprising that the issue of countertransference is not systematically attended to in training, despite the importance and significance this has on being an effective group counselor. In fact, the Association for Specialists in Group Work (2000) fails to mention countertransference as a core training standard, only specifying that a “reflective evaluation of one's personal leadership style and approach” (p. 5) is required as a skill. It should be noted that our intent in this article is not to suggest that countertransference in training is completely ignored or theoretically misunderstood. Rather, it is suggested that resolution of countertransference is an essential skill that requires systematic reflection, discussion, and practice, rather than simply a theoretical understanding.

Countertransference is a core issue that all group psychotherapists and counselors face in their work. Originating in psychoanalytic theory, countertransference has been primarily discussed as a phenomenon to consider in individual work. Freud believed that countertransference interfered with the analyst's understanding of the client, making it essential to attain self-awareness and insight in order to be more effective as an analyst (James, 1979). This was substantiated by other analysts such as Reich (1951), who felt that countertransference feelings were disruptive to therapy, and Heinmann (1950), who believed that understanding the roots of countertransference would contribute to more effective therapy. Later psychotherapists reiterated the importance of insight, asserting that the interpretation of countertransference led to a deeper understanding of clients and personal issues that interfered with therapy (Epstein & Feiner, 1979; Giovacchini, 1972; Herron & Rouslin, 1982; Racker, 1968). Even though it is acknowledged that psychotherapists have reactions to clients, countertransference continues to be an elusive issue in counseling that has not been addressed systematically. This is particularly important when considering group work, which, given the larger number of clients, has expanded opportunities for countertransference.

Within groups, countertransference becomes more complex. Rather than reacting to only one client, the group counselor is now in a position of simultaneously responding to five different levels, which are as follows: (a) individual clients within the group; (b) client interactions with
each other in the group; (c) client interactions with you, the group counselor; (d) the group as a whole entity; and (e) one’s own personal issues and responses that emerge as a result of an interaction of the other four levels. As an example, the first author was doing on-site supervision with a school-based psychotherapist working with a group of high school girls. During the group, two girls engaged in a heated argument about an incident with another friend. As this conflict escalated, two other group members withdrew, clearly afraid of the emotionally charged disagreement. The school-based psychotherapist who was facilitating the group became visibly upset as the two girls argued, trying to stop the conflict and find a quick solution. During supervision, the school-based psychotherapist discussed the need to personally avoid conflict and expressed strong identification with the two girls who withdrew. In an attempt to compensate for that fear, the psychotherapist demanded that the argument stop without any further discussion, suppressing the strong feelings of four of the group members. Facilitating the group became difficult for this psychotherapist, who lost sight of countertransferential feelings and reacted in ways that did not help to resolve the problem or address the issues elicited in the group. Sensitizing this psychotherapist to countertransference in the group reduced future episodes of overreaction to the inevitable conflicts that arise between group members.

Despite the importance of insight into group workers’ own reactions and unresolved issues, little has been written or studied about how to teach students to deal with countertransference. It is our contention that this is a critical deficit in group counseling training that needs to be addressed more systematically. This article will begin with a review of the literature on countertransference in groups, followed by a discussion of the application of countertransference to group counseling. Recommendations will be offered for group counselors in training about how insight into countertransference may be applied in group counseling.

**HISTORICAL PERSPECTIVES ON COUNTERTRANSFERENCE IN GROUPS**

The concept of countertransference has great importance for the group counselor in training (Corey, 2000; Yalom, 1995). Given the greater number of clients in group counseling compared to individual or couples work, there is heightened potential for a group counselor’s countertransference within the group context. Roth (1980) believed that the group counselor’s countertransference is an integral part of the group process, meritizing continuous self-acknowledgment. Group counselors who are oblivious to their own countertransference are distanced
from an important source of information that can affect their depth of insight into group process. Thus, the group counselor’s countertransference is embedded within the group experience rather than being an invisible, intrapsychic event within the therapist.

Roth (1980) observed that “the group offers to the presiding psychotherapist a smorgasbord of psychic events with which to identify” (p. 7). Group counselors must respond to and decipher the issues of individual group members while simultaneously being in touch with their own personal reactions to the group process. This dual role of self-observation and group facilitator requires the group therapist to be more than a detached and passive observer. Group counselors need to be mindful of their inner processes and reactions while being externally active and engaged in the process of therapeutic healing in the group. This dual responsibility leaves group counselors openly exposed and potentially vulnerable within the group. The group is a limitless and rich source of countertransference reactions. Ormont (1991) believed that group therapists benefit from the multiple perspectives of group members who recognize countertransference reactions in group counselors even when the group counselors themselves may be unaware of these issues. Hannah (1984) stated that the group situation is uniquely designed for the group therapist who loses perspective as a result of countertransference reactions, illustrating this with a poignant example of a group therapist who identified with the issues of one group member to the exclusion of others. While the therapist was intensely engaged with a group member, another member, who had not contributed to the group, yawned loudly in boredom. Only at that point did the therapist realize the extent of personal investment in the client’s issue and the subsequent loss of connection with the remainder of the group.

Other multidisciplinary professionals have further highlighted countertransference in models of group leadership training. Counselor educators such as G. Corey (2000) challenged students to look at themselves and to examine how personal characteristics contribute to their effectiveness in group leadership. Stockton and Toth (1996) urged the use of video training methods to allow beginning counselors to watch their own countertransference as it occurred in the group rather than have it pointed out by the instructor. Bieschke, Matthews, Wade, and Pricken (1996) focused on observation as a teaching strategy for training group counselors, placing trainees in groups as silent observers. In psychiatry, a model to deal with countertransference in group therapy was developed for 1st-year residents (Caracci & Stam, 1997) based on the assumption that countertransference is a major source of stress that must be addressed in supervision and training. Simultaneously, a model of training that focused on countertransference for psychiatric nurses
doing group work was developed in the United Kingdom (Lefevre, 1999). It explored reactions of the nurses to group members in a group supervision format, aiming to further develop their skills as group counselors.

Ormont (1991) characterized five stages that lead to uncovering countertransference in group work. In the first stage, a single member, members, or the entire group respond in an unusual way to the group therapist. During the second stage, group members become less responsive and more detached and mechanical. This is followed by the third stage, in which the group therapist recognizes that something is unnatural in the group’s responsiveness and submits to self-analysis to see what personal actions may be contributing to the group’s behavior. In the fourth stage, the therapist, in an attempt to modify personal behavior, finds the group powerfully resistant. This results in the fifth and final stage, in which there is an uncovering of countertransference that leads to improved interaction between the group and the group counselor. Ormont contended that group therapists never understand countertransference until the final stage when deeper feelings behind their personal responses are uncovered. Only in the final stage does the group therapist’s recognition of countertransference create positive movement in the group. Ormont believed that when the group therapist clarifies, resolves, and gains insight into their own personal issues, there is benefit for group members. Additionally, group counselors become a model for honest self-introspection that each group member must emulate in group counseling. By discovering their countertransference, group counselors are able to use their deeper understanding to restimulate the group (Mendelsohn, 1981). According to Brabender (1987), the group therapist’s countertransference reactions are as pronounced as group members’ transferential anger, guilt, hate, love, envy, and fear and are natural and useful in facilitating groups. This may be especially true when group counselors work with emotionally charged issues such as eating disorders, where there may be a strong identification with clients, necessitating good supervision to work through personal issues that may interfere with effective therapy (DeLucia-Waack, 1999).

**GRADUATE TRAINING: GROUP COUNSELING AND COUNTERTRANSFERENCE**

Over the years, there has been limited but occasional attention paid to countertransference in group counselor training. Stoltenberg and Delworth (1987) developed a three-stage developmental model for group counselor trainees that specifically included countertransference. In their model, they described how trainees initially focus on personal
issues rather than those of their clients while drawing from the theoretical base and using learned techniques. During the second stage, as trainees acquire greater independence, the focus shifts from themselves to their clients while developing an ability to select counseling techniques to match the situation. In the third stage, trainees become more keenly aware of their clients and themselves and recognize their own vulnerabilities, strengths, and reactions in relationship to the group members. Within this model, countertransference is most pronounced during the early phases when beginning group counselors are uncertain about group process, their role as group counselors, and their interpersonal styles and relationships. Several years later, countertransference was included in another similar model as a critical component for group therapy training (Gallagher, 1994).

The group counselor's countertransference has the potential to be utilized as a powerful therapeutic force for the group and its leader, given good supervision and training. Mendelsohn (1981) noted how clinical supervision was able to help group counselors connect their countertransference to past life issues and later relate these insights to group process and leadership. It is important to note that gaining awareness and understanding of countertransference in group work is not a simple or quick process. In fact, it could take several months of continued supervision (Cohen, McGrath, & Sharpe, 1991), resulting in more effective therapeutic skills and an improved quality of interpersonal relations between the group therapist and group members. There is a caution that without resolution of one's own issues as a group counselor, there is a danger of exploiting therapy groups (Hannah, 1984).

THEORETICAL ASSUMPTIONS ABOUT COUNTERTRANSFERENCE IN GROUP WORK

Based on the literature on countertransference in group work and our own experience as group counselors, we would make the following seven assumptions:

1. Countertransference is an issue that all group counselors experience (Leader, 1991; Schacht, Kerlinsky, & Carlson, 1990; Spotnitz, 1987; Vannicelli, 2001; Van Wagoner, 2000).
2. There is limited graduate-level training or supervision focusing on learning about countertransference and applying those insights to group counseling (Caracci, 1997; Dempster, 1990; Weinstein & Rossini, 1998).
3. By virtue of a greater number of clients, group counseling creates greater opportunity and likelihood of countertransference (Flapan & Fenchel, 1984; Yalom, 1995).
4. Being unaware of one's emotional responses and unresolved issues is a barrier to effective group facilitation (Flapan & Fenchel, 1984; Hayes, 1995; Hein, 1995; Lefevre, 1994; Moss, 1995).

5. Understanding one's own countertransference leads to greater effectiveness as a group counselor and adds to the potential richness of the group experience (Hein, 1995; Moss, 1995; Yalom, 1995).

6. Countertransference may involve emotionally charged responses such as strong feelings of responsibility, control, withdrawal, anger, love, hate, annoyance, powerlessness, emotional avoidance, collusion, overidentification, or sadness (Bemak & Epp, 1996; Bernstein & Klein, 1995; Hanh, 1995; White, 1994).

7. Supervision and training that systematically examine countertransference in group work are essential at the graduate level (Caracci, 1997; M. S. Corey & Corey, 1997; Weinstein & Rossini, 1998).

**TYPICAL COUNTERTRANSFERENCE RESPONSES**

Based on these seven theoretical assumptions, observations working with groups, and the first author's experience as a trainer and supervisor for group counselors, we would identify five common countertransference responses that occur with regularity in group counseling. First is the group counselor who is emotionally withdrawn and remains emotionally unavailable to the group. This response may result from a fear of being vulnerable within the group and wanting to maintain distance, sometimes under the guise of professionalism. The emotionally distanced group counselor may be consciously or unconsciously defending against the group as they attempt to engage him or her, resulting in feelings of being attacked and causing further withdrawal. A second countertransference response is passivity. This may stem from feelings of insecurity about skill level and ability, especially during graduate training or when working with a particularly difficult group. A third response is the overly controlling group counselor. This group counselor generally prefers structure and is uncomfortable with allowing group process to evolve. Essentially, the overly controlling group counselor inhibits interpersonal process and issues that are personally difficult. The group counselor who adopts a style of facilitation that is highly restraining and directive assumes responsibility for group members' interactions and the resolution of group problems. A fourth countertransference response by group counselors consists of a personal regression to maladaptive behaviors based on their own unresolved issues. For example, the group counselor who becomes angry with the group for having conflict or not being cohesive may be reexperiencing his or her own family dynamics. A fifth response is the group counselor who is too paternalistic and adopts a role as the rescuer. This, too, is often-
times a result of unresolved family issues that result in protection of group members and a disempowerment to work on difficult interpersonal concerns.

RECOMMENDATIONS FOR TRAINING IN GROUP COUNSELING

Systematically addressing countertransference in graduate-level training is essential in understanding the interrelationship between insight into unresolved personal issues and effective group facilitation. It requires a clear delineation to trainees about the importance of understanding and applying countertransference to their work as group counselors. Based on the seven assumptions regarding countertransference listed above, we would offer seven recommendations for faculty and site supervisors working with graduate-level trainees studying group counseling. It must be cautioned that understanding and gaining insight into countertransference requires a steady balance and clear boundaries so that the group counselor is not working out personal issues at the expense of the group. Rather, the effective group counselor would be able to maintain an emphasis on group members’ needs and apply countertransference insights accordingly. The seven recommendations are described below.

1. It is important that group counseling training incorporate a strong affective component in group supervision. Inclusion of a strong affective component during supervision would establish an acceptance of working with deep-rooted feelings and reactions within the context of group supervision and group counseling. This is essential in creating safety and comfort to explore a deeper level of emotional response and instills a norm of examining emotional reactions within group supervision.

Examining affect during group supervision would require an ongoing focus by the supervisor for students in training to examine their own psychological processes as they relate to events and interpersonal process within the group. How they feel about what is going on, what their response is to this process, and where these responses originate are important issues to examine. This emphasis on affect is particularly important and somewhat challenging because graduate students typically emphasize the acquisition of knowledge and cognitive levels of understanding during their formative years of training.

An example of this was evident during supervision with a group of graduate students. One of the trainees was struggling with feelings of dislike and resentment toward a group member who she felt "did not
participate enough in group.” The supervisor probed with the student and other trainees about the feelings associated with the dislike and possible origins of these feelings. Further examination helped the student realize that the group member reminded her of her sister and elicited strong feelings of anger and resentment. Becoming aware of this, her feelings and later responses toward the group member substantially changed.

2. A second recommendation would be to move toward group counseling trainees’ emotionally charged material rather than away from it in group counseling supervision. The respect and attention paid to poignant affective reactions is essential in understanding countertransference and its impact on group counseling.

Maintaining a focus on strong emotional reactions is oftentimes difficult to initiate or sustain. It is recommended that explicit norms be established at the beginning of supervision that explain the necessity for examining personal reactions and feelings as a group counselor. Furthermore, it is helpful to establish that at times, exploration of these issues may be difficult but is essential in developing as an effective group counselor. It then becomes more acceptable to concentrate on these issues as they emerge within the context of supervision.

As an example, the first author supervised a male group counselor who was facilitating a group in which one woman was particularly rude and insulting to the males in the group. The counselor was very angry and upset with her, but any attempt to explore the dynamics between the female client and the males in the group was attacked. The counselor became increasingly angry but was not sure how to respond, felt trapped by the client, and became quieter when confronted by the client in group. During group supervision, in a highly emotional session, it became clear that the group counselor was reminded of strong feelings of being trapped at other times in his life. The permission to explore his powerful reaction and subsequent insight during group supervision allowed the counselor to move forward and effectively work with this individual in group.

3. The supervisor must remain personally engaged and active in the process of supervision, rather than being distant and removed, to elicit deeper emotional responses by trainees. This entails maintaining a balance of objectivity and professionalism while also staying highly engaged. Remaining attentive and focused on affect in group supervision is important modeling for the trainees that is relevant to parallel process (DeLucia, Bowman, & Bowman, 1989) and assists in understanding countertransference. The modeling assists trainees to appropriately share their deeper personal experiences and reactions with students.
Personal engagement and modeling is best done in the here and now during group supervision so that supervisees are exposed to modeling self-disclosure in ways that are beneficial and appropriate for their growth. This would involve the supervisor’s sharing personal reactions to supervisees, taking risks, and engaging in honest dialogue about their work.

An illustration of this is the supervisor who may experience strong annoyance toward one trainee for continuing to ask questions about group process. The supervisor feels that these questions are repetitious and irrelevant, but with further reflection realizes the student has similar qualities to a person with whom the supervisor recently ended a significant relationship. Examining this openly with the group and explaining how these unresolved personal issues can interfere with group process and facilitation is an important lesson for trainees.

4. It is recommended that supervision occur within a group context. Because groups provide more opportunity for countertransference, and the trainees are facilitating groups, it is recommended that supervision occur within the context of a group that would last for a period of 1½ to 2 hours and involve five to six supervisees. This promotes a parallel process for the group supervisees, who can now apply what is happening in their own supervision and with their supervisor to their group counseling experience. The process of the group would afford opportunity for multiple perspectives regarding group counseling and have the potential to more effectively examine countertransference issues (see Recommendation 6). The benefit of having multiple perspectives within the dynamic process that groups afford is invaluable to future group counselors.

5. Another recommendation is for the supervisor to take risks when sharing and discussing countertransference. Risk taking by faculty and site supervisors is important modeling. G. Corey (2000) postulated that for trainees to develop their ability to take calculated risks is not only important but requires courage and willingness. Establishing risk taking as a norm in group supervision is particularly important with regard to countertransference.

Although risk taking is essential and a highly valued quality, it is important to take calculated risks rather than arbitrary ones. Similar to counseling interventions, timing is crucial. The supervisor must evaluate the readiness of the trainee as well as the group itself to work with the issues presented in a risk-filled intervention.

A case in point was evident in an experience of the first author when running a therapy group with Native Americans. Although there was a tremendous respect and openness in the group, members were exploring new and deeper levels of intimacy and sharing. One member, a 30-year-old, 6-foot 6-inch professional man who was highly competent and a leader in his nation shared how he missed his childhood and sometimes
needed attention and care. The group therapist had an instant inner vision of parenting this man, feeling deeply for his loneliness. After a quick millisecond check to determine that it was not the group therapist's issue that warranted further reflection, the therapist took a risk and said, "I just had a deep feeling of compassion and caring for you. How does that make you feel?" This question opened up the group for an in-depth exploration about their feelings of care for this individual, who was moved to tears by the therapist's and group's response.

6. Teaching students how to carefully and positively frame and discuss their countertransference reactions is another recommendation. Sharing or discussing deep feelings about clients or supervisees involves serious work. It is important to learn how to explore these deeply rooted feelings toward others in ways that do not offend, alienate, or harm group members or graduate students. A poor presentation or interpretation of countertransference can be emotionally devastating to a client or trainee.

It is recommended that to teach students to openly and positively discuss countertransference there is a gradual and appropriate modeling, framing, and sometimes correcting of students as they discuss these issues. This should be done from the onset of supervision and would parallel the establishment of trust and cohesiveness within the group supervision. Initially, a supervisor would be less confrontational and challenging of trainees. Later, when a solid supervisory relationship is established, discussion about countertransference may be more direct and open, although continuing to maintain positive ways of examining delicate and emotionally charged issues.

An example of this can be seen within group supervision with one graduate student who is being challenged by other group members about paying more attention to one group member. During early stages of supervision, the supervisor might ask, "How were you feeling when the client told you that you seemed to pay more attention to the older group members?" This presents a way for trainees to openly talk about their process and issues. Later in the supervision, the supervisor's response may take another form such as, "I see you are struggling with paying attention to age again. What is going on for you now?" Each of these responses is appropriate developmentally and opens discourse and discussion in a constructive manner.

7. A final recommendation involves the need to create supervision that facilitates a critical self-analysis of countertransference by students. Analysis of countertransference is really a form of self-therapy and is essential in the development of a beginning group counselor. The aim of group supervision is to accentuate the awareness and attention of gradu-
ate students to countertransference, assisting them to further explore personal reactions and unresolved issues independently, outside of the supervisory relationship.

Supervisors can introduce self-analysis during group supervision. It requires the supervisor to allow the supervisees’ interpersonal process to emerge during supervision and to support their struggle and work with their countertransference. To successfully introduce this, there must be ample time structured in group supervision of 1½- to 2-hour sessions. Self-disclosure is encouraged along with feedback, comments, reactions, and observations from participants in the supervision. Conducting supervision sessions in this manner establishes a norm for interaction about countertransference while constructing safety to do so.

CONCLUSION

Countertransference is a frequently neglected process in group leadership training. Brabender (1987) argued that group therapists’ commitment to explore and understand their countertransference is more important than any theoretical orientation. The lack of systematic attention to countertransference in the training of group counselors is a noticeable gap in graduate training. Given the importance and benefit that has been attributed to identifying and understanding countertransference in groups, we would suggest that training incorporate identifying, analyzing, and strategically using countertransference for effective interventions. The exploration of countertransference, both didactically and experientially, should become a milestone in the development of the effective group counselor.

REFERENCES


Planned Group Counseling:
A Single-Session Intervention for Reluctant, Chemically Dependent Individuals

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Planned group counseling (PGC) is a group intervention used for 20 years at an urban Veterans’ Affairs medical center’s methadone maintenance treatment program and substance abuse rehabilitation programs—detoxification, 28-day inpatient, and 2-year outpatient. PGC was added to these interdisciplinary programs to provide a conjoint group treatment method. The method integrates concepts and techniques found in both professional and self-help groups. It is leader centered, very Directive, and based on a single-session, highly structured workshop model. PGC is intentionally designed to cope with the very reluctant behavior common to this population: lateness, irregular attendance, premature terminations, and noncompliance with therapeutic directives.

There are many chemically dependent people needing psychological help. In the United States, 18 million people are chemically dependent on alcohol and 5.5 million on other drugs (Geller, 1996). Between 15% and 30% of hospitalized clients have a chemical dependency problem (Geller, 1996). Many of these people who request psychological treatment are ambivalent about changing, not ready and/or unable to commit themselves to regular attendance patterns and unable to cope with the confrontations, conflicts, and intimacy demands inherent in many psychological group treatments. They are afraid, distrustful, and even hos-
tile toward existing professional group treatments and frequently terminate their treatments prematurely. Skinner and Drake (1997) noted that chemically dependent patients’ past experiences with dealers, drug-using peers, and the legal system have taught them to be secretive, and that they have been living in a social environment where dishonesty and manipulation have been the norm. How can professionals engage and better retain such people in treatment without abandoning important traditional psychotherapeutic goals? Harris (1995), after citing a few full-length works (Collins, 1969; Harris and Watkins, 1987; Meloy, Haroun, & Schiller, 1990; Rooney, 1992) and some examples of well-focused articles on counseling reluctant patients (Arcaya, 1978; Berman & Segal, 1982; Dyer & Vriend, 1973; Larke, 1985), concluded that during the past 20 years, little comprehensive attention has been paid to the problem of working with involuntary and resistant clients.

One solution is to create a group method that better matches reluctant clients’ needs. Miller, Zweben, DiClemente, and Rychtarik (1992) noted that chemically dependent patients who are very ambivalent about change need counseling methods that enhance their readiness to change. Prochaska (1997) believed that health professionals “need to match the needs of people in each stage of change rather than expect their clients to match their favorite treatment modality” (p. vii). To accomplish this, the first author created a new group method, called planned group counseling (PGC), by carefully selecting and reorganizing a variety of fundamental concepts and techniques found in a range of traditional psychological group treatments as well as self-help and/or religious group experiences. The method is designed to be more inclusive, accepting, accommodating, and protective of patients who do not meet the assumptions of traditional group treatments while safely achieving limited but important psychotherapeutic goals. Over the course of more than 20 years, this specialized group method was used in several thousand group sessions at a large, urban veterans’ affairs medical center (VAMC) and was taught in the clinical psychology internship program where the second and third authors were trained.

This group method was originally created for patients in the day hospital psychiatric program and then modified and primarily used for the methadone maintenance treatment program and substance abuse rehabilitation programs (SARP)—detoxification, 28-day inpatient, and 2-year outpatient. These patients were primarily male World War II, Korean, and Vietnam war veterans. Many suffered from Axis I and Axis II disorders, post-traumatic stress disorder, physical ailments (diabetes, heart conditions, HIV positive/AIDS), and physical disabilities as a result of combat. Many were unemployed, homeless, in debt, and estranged from their families, and some had pending criminal charges and past incar-
cerations. Many of these patients were either not ready, conflicted, or only partially committed to change—"contemplators" in Prochaska and Norcross's (1994) taxonomy. They were frequently highly defended, emotionally underdeveloped, fearful and distrustful of others, and had severe time management and intimacy problems characteristic of the so-called drug lifestyle, regardless of their selected drug of abuse (Walters, 1994).

Monti, Abrams, Kadden, and Cooney (1989) believed that social skill deficits undermine these patients’ ability to change maladaptive addictive behaviors and that chemical dependency may serve an adaptive function, namely, helping patients cope with intolerable emotional experiences. Huey (1991) noted that relapse prevention programs are based on learning theories that are designed for mildly to moderately impaired patients, although in some treatment programs the majority of patients are severely impaired. Thombs (1999) maintained that researchers have ignored studying patients who demonstrate little or no commitment to recovery and that some relapse prevention strategies assume that all patients are equally motivated to change. Core elements of psychoeducational, theme-oriented, and behavioral approaches include punctuality and regular attendance, assuming patients can effectively manage their time and are committed enough and ready to change their maladaptive behavior. Psychodynamic, interpersonal, and person-centered group treatment models—even when highly modified—add to these assumptions the idea that these patients are able and willing to tolerate interpersonal conflict and confrontations, intense and unwanted new emotional experiences, and the inherent intimacy demands in these group treatments (Corey, 1995). Many patients want to believe they are capable of meeting these assumptions and often effectively convince others that they can be compliant with the demands of treatment, but many simply cannot.

The purpose of this article is to describe a replicable model of a specialized group method structured to treat voluntary and involuntary (court-ordered) chemically dependent patients as a conjoint, orientation, and/or maintenance group treatment method for interdisciplinary substance abuse treatment programs. This group method has also been used with day-treatment psychiatric patients and could also be potentially useful to treat a range of other reluctant clients in a variety of settings in which group treatment is offered. For clients in mandated counseling and prison settings, this group method might be helpful as an independent alternative group method or conjointly with other treatment methods. The authors view individual therapy as offering greater protection and a sense of safety for many clients but see group treatment as advantageous for those who are chemically dependent, because inter-
personal learning is more accessible. The group context allows discouraged, reluctant, and unmotivated patients to observe and learn from each other how clients similar to themselves may benefit from treatment. Even in generic outpatient settings, PGC might be used as an orientation and transitional group treatment to standard group counseling. As an alternative group method, PGC may help address the needs of premature terminators from standard group counseling, especially to help prevent high-risk patients (potentially suicidal and homicidal) from becoming more alienated and rejecting professional group treatment altogether.

This article presents the overall model for the group and explores in detail the method's very accepting, highly protective group process. An example of a PGC session is provided, followed by a brief discussion of the method's advantages, limitations, and potential uses.

MODEL FOR THE PGC GROUP

Theoretical Framework

PGC's method integrates theoretical concepts derived from a variety of theories—humanistic, gestalt, cognitive-behavioral, and others—not for the sake of achieving a clever or fashionable eclecticism but to accommodate the particular needs of chemically dependent patients. Toward this end, PGC espouses the following five principles, supported by both the literature and clinical experience: (a) The efficacy of the PGC method hinges on the quality of the relationship that the group leader is able to establish with each member of the group. The therapeutic relationship has been seen as a central curative agent in the experiential tradition (Rogers, 1951, 1957) and continues to be conceptualized this way by contemporary experiential theorists (Greenberg, Rice, & Elliott, 1993). Safran and Muran (2000) concluded that “after approximately a half century of psychotherapy research, one of the most consistent findings is that the quality of the therapeutic alliance is the most robust predictor of treatment success . . . across a wide range of treatment modalities” (p. 1) (c.f. Garfield, 1992; Young, 1992). Harris (1995) stated that the development of empathy is more crucial for counselors of treatment-resistant patients; acutely aware of this, the PGC leader strives to communicate the highest level of respect, support, acceptance, and empathy to each and every group member; (b) each person is inherently curious and capable of further psychological development. The ethos of PGC is consistent with a model of development across the life span (Erickson, 1950; Murphy, 1958; Sullivan, 1953) and is also accepting and affirming
of individual differences (Kelly, 1963). These values are put into action via the curiosity, respect, and empathy that the PGC leader shows toward each group member; (c) important psychological learning takes place in a variety of ways and can occur at any time. PGC’s self-contained workshop format is akin to the brief therapist’s view of each session as potentially the “first, last and only” (Talmon, 1990). In a figure/ground reversal, PGC shifts the therapeutic focus from resistance to each individual’s acceptance of responsibility for his or her thoughts, feelings, and degree of commitment to psychological treatment (c.f. Glasser, 1965). Members are, of course, encouraged to attend additional sessions to obtain additional benefit: one-trial learning, vicarious learning, and learning through imitation (Bandura, 1986) are all valid pathways to the development of helpful behaviors; (d) irrational thoughts and emotions outside of awareness, especially those that are in conflict, can cause chemically dependent patients to relapse (Brill, 1938; Ellis & Bernard, 1986). The PGC leader regularly uses psychological exercises to demonstrate the importance of these psychological processes; (e) honest communication of thoughts and feelings is necessary for psychological well-being. These skills are critical to help form and maintain interpersonal relationships (Yalom, 1995), an area in which chemically dependent patients typically have few positive experiences to draw on. Knowing when, how, and what to self-disclose is a very complex issue, as is knowing when and how to caringly confront another (Jourard, 1971).

Sensitive to patients’ deficits in this area, the PGC leader encourages group members to express their thoughts and feelings only to the leader, in a dialogue fashion, thwarting aggressive or premature confrontation from other group members. Despite the limitations imposed on member-to-member interactions, focusing on expressing thoughts and feelings in the here and now gives the patient an opportunity to practice verbal self-expression (vs. acting-out behavior). Emphasis on the authentic and present-moment quality of the patient’s experience provides a common group experience, increasing the patient’s relatedness to others (Perls, 1969), albeit incrementally.

**PGC Goals**

The goals of PGC, both interpersonal and intrapsychic, were selected to match the needs of very reluctant patients while engaging them in limited but significant therapeutic tasks.

The interpersonal broad goals are to (a) invite and engage each patient in a psychological dialogue that seeks to obtain the patient’s cooperation and compliance with the leader’s psychotherapeutic directives; (b) provide a supportive, protective, group experience that mini-
mizes conflicts and maximizes interpersonal learning between group members; (c) accept and accommodate patients who are very conflicted about changing or receiving psychological help, unable and/or unwilling to manage their time, and who attend group treatments irregularly; (d) provide an opportunity for each patient to communicate and be affiliated with others and to be a significant and needed participant in the group’s tasks; (e) encourage patients to always be responsible for determining when and how much to participate and self-disclose.

Interpersonal specific goals are to (a) offer patients opportunities to learn and practice self-control, and self-disclose their thoughts and feelings without harming themselves and/or others; (b) give patients an opportunity to experience the positive effects of honestly and verbally expressing thoughts and feelings to an empathetic listener; (c) practice listening and encourage patients to be more empathetic toward others; (d) reinforce patients’ efforts to seek and accept help from supportive friends and family members, self-help and religious group experiences, and all needed professional services.

The intrapsychic broad goals are to (a) encourage patients to practice self-reflection, and (b) increase patients’ self-awareness and self-acceptance and encourage them to direct their attention to and accept responsibility for how they perceive, feel, think, and act in the here and now, and compare these experiences with their peers.

The intrapsychic specific goals are to (a) help patients recognize and label helpful and harmful thoughts (especially irrational thoughts), feelings, and actions; reinforce those that are adaptive; discourage those that are self-defeating; (b) help increase their awareness of and their ability to better tolerate unwanted emotional experiences, for example, feelings they tend to deny and avoid (anxiety and sadness); (c) increase patients’ awareness of how thoughts and emotions, especially thoughts outside of awareness, can contribute to helpful and harmful behavior patterns.

The above goals are an attempt to facilitate self-change, leaving it to patients to make their own choices about changing self-defeating behavior that is a consequence of the misuse of legal and illegal chemicals.

**Member Selection**

PGC leaders use a minimal exclusion criteria. As a general guideline, all chemically dependent patients can be screened by intake staff, requiring no further screening by PGC leaders with the exception of those acute patients requiring either immediate psychiatric care and/or detoxification. These patients can then be referred to other program treatment staff.
**Group Size**

Group size is variable and unpredictable, but it is the authors’ clinical observation that a group of 15 to 20 members is ideal for this group intervention. A slightly larger group might still be acceptable, especially if there is a coleader, in which case the group can be divided in two provided there are adequate physical resources.

**Physical Environment and Materials Needed**

Ideally, a large, light, airy, and quiet room with separate entrance and exit doors in front and back of the room is desired. For 20 group members, the room should accommodate 20 movable chairs, which the leader arranges as three sides of a square, an equal (roughly) number of chairs per side, with a large blackboard and chalk (or something comparable), and one chair in front of the blackboard for the leader, which completes the square. The corners of the square should be left unclosed for easy access and exit by members. On the blackboard, the leader writes the following: (a) the leader’s name and title; (b) one broad and one specific interpersonal or intrapsychic goal, determined by the objectives and the topic being explored for that day; and (c) an outline of the session’s plan.

**Member Preparation and Orientation**

Intake staff briefly assign members to regularly scheduled PGC groups. Members need no prior preparation before entering a PGC group. The leader orients all present members on their entering the group and then, briefly, each new member as he or she arrives. The leader welcomes them, warmly invites them to sit wherever they wish, but requests that they please remain in their seats. The leader then tells members that this group method may be different from any group method they have experienced; that it was especially created to accommodate lateness, varying attendance patterns, and differing levels of commitment to change. The leader points to the PGC goals that are written on the blackboard, briefly explains them, then tells members that there is no confidentiality requirement in this group. Therefore, before disclosing any thoughts and feelings, they should consider this fact. Members are also told that whenever the leader asks them a question or invites them to participate in any exercise, they are always free to respond by “passing.” They are asked to refrain from asking any question or making any comment to any group member and are told that they will be given repeated opportunities to freely express any thoughts and/or feelings and direct any questions and comments they have about the
group experience, but only to the leader. The leader explains that their cooperation and compliance with the directions is necessary to maximize the PGC learning experience while minimizing potential confrontations and conflicts.

Organization of Sessions

The PGC method is a planned, 1-hour, open-ended, single-session workshop model. The model provides optimal frequency possibilities from a one-time session to daily sessions, depending on a program’s or professional’s objectives and resources. Each session is conceived of and conducted as a self-contained social, educational, and therapeutic learning experience. Punctuality, participation in full sessions, and regular attendance are encouraged, but members have the freedom and responsibility to determine when they come and go. These norms are similar to those of self-help and religious groups. The PGC method assumes past or future attendance is not necessary for a member to benefit from a PGC session. As stated previously, PGC is similar to individual brief therapy, where each session is potentially the first, last, or only therapeutic encounter (Talmon, 1990; Walter & Peller, 1992). By contrast, one of the ways in which PGC differs from planned single-session therapy (Bloom, 1992) is that members are actively encouraged to return regularly. The leader uses a different topic for each session to accommodate the returning members.

CONTENT OF SESSIONS
AND GROUP PROCESS

The PGC Plan

Similar to psychoeducational, large-group awareness training and highly structured, theme-oriented approaches, PGC always starts out with a plan to explore a topic. The plan is the means to a safe, calm, harmonious interpersonal climate where mental activity of self-reflective consciousness and disclosure are encouraged. Critical to the plan are carefully prepared psychological exercises focusing a member’s curiosity on self and others and encouraging them to increase self-reflection and practice listening to others. The principles for the creation and selection of exercises are to (a) consider their demands relative to the patient’s capabilities; (b) directly relate them to PGC’s goals as outlined above and explained by the leader when introducing the exercises; and (c) provide both a cognitive and affective component.
The basic PGC plan, or format, contains the following components: leader’s welcome; minilecture followed by questions and comments; psychological exercises, including word-association and psychological question; and group members’ final questions and comments. Questions and comments might also be used after the word association and psychological question, based on the leader’s clinical judgment. A detailed description of this plan, or basic format, can be found in the replicable example that follows later in the article.

The plan is always subject to revision. Whenever an interaction occurs either between members, member/s to leader, or leader to member/s that focuses the group’s attention and stimulates curiosity, this becomes a direction decision point for the leader: Is there greater therapeutic potential and would the group be better served by diverting from the plan? The leader may choose the method of observant participation, where members’ emotional reactions and the group’s behavior become the focus of observation and objective analysis. For instance, a conflict may arise between a member and the leader due to a different meaning attributed to a specific word, for example, help. The leader can choose to label this a miscommunication and use it as an opportunity to explore this issue from a gestalt perspective—how each member is responding to what just happened then becomes the focus. Or the leader could choose to divert from the plan by inviting each member to define the word help, thus demonstrating differences and similarities between members and permitting them to gain a here-and-now awareness of what they are sensing, feeling, and thinking (Perls, 1969).

Group Process

PGC uses a highly directive, leader-centered approach to promote the effects of the following therapeutic factors: instillation of hope, universality, imitative behavior, imparting information, altruism, and development of socializing techniques (Yalom, 1995). It relies on leader-to-member/s and member/s-to-leader interactions occurring in a brief, orderly, genuine manner to avoid the creation of harmful and destructive interpersonal conflicts that may occur in group treatments that depend on free member/s-to-member/s interactions, even when “acting in” behaviors, for example, verbal abuse, are prohibited (Nitsun, 1996; Ormont & Strean, 1978). Free interaction of member/s to member/s is not essential to achieve PGC goals, and therefore, the group process is most similar to approaches where the free interaction of member/s to member/s is not central and does not define the group process, as in psychodrama, gestalt, large-group awareness training, transactional analysis, behavior therapy, and psychoeducational/theme-oriented ap-
approaches. It differs most from traditional and modified group treatments that encourage and rely on members freely interacting, such as psychodynamic and interpersonal group models (Corey, 1995; Lieberman, 1994; Yalom 1995). Although the leader only encourages member-to-leader communications, member/s-to-member/s communications do periodically occur. Paradoxically, the leader does not devalue them; these interactions present an opportunity to use them therapeutically, for example, to explain why members are being asked to restrict communications to the leader.

PGC relies on the leader's ability to engage each member and have him or her perceive the leader as their protector and helper. The leader invites each member to help create a group process by verbally responding to the leader's questions and comments, by briefly verbalizing their thoughts and feelings, and by assuming the role of participant-observer who gives feedback under the guidance and direction of the leader. As participant-observers in a common psychological group experience, they are asked to respond to specific directives and observe their responses and compare them with their peers. Group cohesion develops as more members increase their participation in the group's task. Compliance and noncompliance with the leader's directives provide the here-and-now behavior to be analyzed and changed, comparable to Yalom's (1995) “grist for the mill.” The authors have observed that even with the discouragement of free member/s-to-member/s interactions, there is some grist for the mill, which is similar to that used in psychodynamic and interpersonal group treatments whose leaders give directives designed to promote member/s-to-member/s free interactions, intentionally exposing members' intrapsychic and interpersonal maladaptive behaviors and providing an opportunity to correct them.

To constrain member-to-member interactions, the PGC leader gives clear directives (e.g., “Speak only to me.”). This establishes a relationship with each new member and generates action in the present by discussing the directive. The PGC leader, like traditional group leaders, can still analyze and interpret how each member and the group as a whole are responding to the directive, focusing attention as needed on the group process issue of compliance, cooperation, and resistance to the group task.

The PGC leader's confrontation of noncompliant behavior as a whole creates a group process similar to gestalt, psychodynamic, interpersonal, and person-centered group approaches, because although the PGC leader seeks to minimize member/s-to-leader confrontations, these confrontations are not discouraged. Members are repeatedly and regularly invited throughout the session to freely express thoughts and feelings to the leader. This provides more protection for members because
the leader’s training and experience are guiding the interpretations and handling of potential confrontations, challenges, and rejection of the leader’s directives. In PGC, the leader assumes responsibility for what happens between members and offers each member protection and safety while giving patients a vicarious learning opportunity and potentially activating their capacity for imitative behavior (Bandura, 1986). The therapeutic dialogue between the higher functioning members and the leader provides a model of more adaptive social behavior.

Leadership and the “Going Around” Technique (GAT)

The leader protects and supports all members by being vigilant and quick to confront destructive interpersonal behavior and by setting limits, for example, “No touching and remain in your seats.” The leader challenges members to recognize their strengths and accept responsibility for their choices, and confronts and interprets individual members’ and group’s defense mechanisms and reluctance to follow the group norms. To help cope with not knowing how many new and returning members might be entering the group at any given time and what mental state they are in, the leader frequently assumes a didactic and director leadership role and relies regularly on the GAT.

Spitz and Spitz (1999) credited Alexander Wolf with originating the use of the go-around, or round robin, technique (asking members to comment in succession) to further his individual psychoanalytic goals in a group. Serendipitously, Wolf and Schwartz (1962) observed its usefulness to activate interactions between group members. GAT is often selectively used in groups depending on member/s-to-member/s interactions to achieve their therapeutic goals. The PGC leader uses GAT in a modified manner; it is never used to generate member/s-to-member/s interactions, thus limiting intrapsychic and interpersonal therapeutic goals. Nevertheless, it allows patients to further develop listening skills, practice verbalization of thoughts and feelings to the leader while the group listens, experience being listened to by the leader and other attentive group members, and receive caring, confrontational, supportive, and empathetic responses from the leader. The leader always gives members freedom and responsibility for self-disclosing; they are repeatedly reminded that whenever the leader asks them for questions or comments, they may say “pass” rather than self-disclose.

The authors believe increased self-awareness is furthered by a member’s observing how his or her thoughts and feelings are similar to and different from others. This promotes the therapeutic effect of universality and reveals a member’s uniqueness (Yalom, 1995). GAT is the pri-
mary contributor to achieving this goal and creating the PGC group process. The leader engages each member systematically, addressing the member by name or asking the member to say their name, initiating a therapeutic dialogue while the group listens and observes this transaction. The uniform execution of GAT reveals each member's ability to understand the task and willingness to comply with the leader's directives. The authors observe that most members readily accept this technique. The speculation is that the demands of GAT are easy to understand, brief, nonthreatening, and equally applied; the dyadic transactions of leader and member are embedded in a common group experience; members are invited to respond, and all responses are accepted and treated respectfully; the leader communicates a sincere desire to understand each member's subjective experience and assist in their psychological development. Within this very protective, therapeutic, interpersonal group situation members feel secure and free to learn about themselves and others.

REPLICABLE EXAMPLE OF A TYPICAL PGC SESSION

Leader's welcome. Time: 2 to 3 minutes. Precisely at the group's scheduled time, the leader introduces himself or herself to all present and welcomes and orients them to PGC, as previously described. The leader always welcomes everyone, including latecomers, thereby reinforcing each member's efforts to attend.

Minilecture. Time: 5 to 10 minutes. The minilecture is designed to engage and warm up the members to the process of listening and reflecting. The leader begins by announcing the topic, for example, “Today’s session will focus on interpersonal behavior: you asking help from others.” He or she defines unfamiliar terms such as interpersonal and provides a brief rationale of the topic, for example, pointing out the differences between physical and psychological assistance and describing how asking for and needing physical and psychological assistance changes over a person's life span. The leader completes the segment by asking each member for questions and comments, during which the following typical member-to-leader interaction is not uncommon: A member loudly exclaims that “another member is taking too long to make their comment, and this member always talks too much.” The leader will initially protect the member from this unsolicited criticism by reframing the behavior as a learning opportunity for the criticizing member: The leader says, “Sometimes it is not easy to listen to people
Psychological exercises. Time: 30 to 35 minutes, including the word association and psychological question. The leader introduces the exercises by saying, “Just as it is important for us to do physical exercises to maintain our strength and to be able to cope with the physical demands of living, so too do we benefit from doing psychological exercises to maintain our self-esteem and to better cope with the psychological demands of living and relating to others. At times we all have thoughts and feelings that are unwanted and potentially harmful. We are less likely to act upon our harmful thoughts and feelings if we are aware of them and if we can communicate them to others who care about us.”

The leader tells the group, “All exercises in PGC are very carefully selected to help each member become more aware of their perceptions, emotions, thoughts, and actions, and if they choose, to learn ways of experiencing and behaving without harming themselves or others.” The leader emphasizes “There are no trick questions and they do not have right or wrong answers.” The leader asks for “brief and honest” answers, which are written verbatim on the blackboard. If a member chooses to pass, “pass” is written as their response. The leader interprets the pass response to the group as the member’s acceptable and authentic behavior: better to pass than to respond dishonestly, because practicing honest communication is one of PGC’s goals. When a member repeatedly passes or a pattern of passing is observed, the leader may choose to confront the member if, in the leader’s judgment, the member can tolerate and potentially benefit from additional attention. Then the leader will continue to
engage the member in a therapeutic dialogue to better understand his or her behavior. For example, leader: “You have repeatedly passed. I am curious: Are you passing because you are not ready to say what you think and feel or do you have some other reason?” After a slight pause, the leader continues, “Of course you do not have to answer this question, you can choose to pass again.” If the member responds with another “pass,” the leader can then say, “Good, it is always up to you to decide when and how much to contribute to this group, and always better to pass than make up some response.”

**Word association.** Time: 10 to 15 minutes. As an example, the leader writes the word *help* on the blackboard and uses GAT to ask each group member what single word or short phrase they become aware of when they hear the word *help*. The leader records verbatim each member's response and praises the group for their cooperation and compliance. The leader then analyzes the responses as a set, for example, commenting on similarities and differences and suggesting thoughts and emotional reactions that people may have to needing and receiving psychological rather than physical help. Depending on the members' needs and the leader's clinical judgment, some time might be allocated to answering members' questions and comments.

**Psychological question.** Time: 20 minutes, including analysis and questions and comments. The authors often use the following question: “Why should you not accept professional help for your chemical dependency problem?” The leader qualifies this question by saying, “I believe you should accept professional help because other people with similar problems have been helped by professionals. One of the goals of this group is to convince you to consider accepting psychological group help as well as self-help and religious groups, if needed.” After the leader has written the question on the blackboard, he or she reads it slowly and, using GAT, systematically asks for each member's answer, which is written verbatim on the blackboard, and while doing this, reminds the group that they should please not comment on each other's responses. However, not all group members consistently follow this directive. For example, a member angrily criticizes another member's response by saying “That's a stupid answer!” In this case, the PGC leader confronts the member and asks him or her to direct these hostile comments only to the leader and reminds the member and the group that although they are to restrict their communications to the leader, what they verbalize is totally unrestricted if it's truthful. The leader then engages the member in a therapeutic dialogue as a way of expressing concern and a desire to understand why the PGC process is difficult for this member, while the
member’s peers observe the interaction. This interaction provides an opportunity for the member to save face, because the member can target his or her anger to a safe person (the leader). The leader then acknowledges to the group that although this member’s comments would be interpreted in other social groups (family, friends, jobs) as hostile, the leader would praise the member for making a brief, direct, verbal expression of his or her honest thoughts and feelings to the leader as they occurred in the now—which is one of the group’s basic tasks. The leader would say that although he or she accepts what the member has said, it does not mean that he or she agrees with or approves of the comments. Therapeutically, it is important for the leader to always accept and respect their subjective experiences but not necessarily to agree with or condone them, because what they think and feel may be very harmful to themselves and others. Honest responses present a PGC leader with a challenge and opportunity. The challenge: to accept and respect members when they are behaving in ways that usually elicit anger and/or rejection from others. The therapeutic opportunity: to demonstrate to other members that this member’s destructive comments can be understood as extremely defensive. The leader might then say, “This doesn’t make [person’s name] very much different from us, since many of us act out when we are very conflicted about acknowledging and changing our harmful behavior patterns.”

Hostile comments by member to member and subsequently member to leader always create an attentive audience, thus offering the leader a therapeutic challenge and opportunity. The challenge is to win this member’s cooperation and compliance with the PGC norms; the opportunity is to demonstrate to the group how the psychological approach seeks to understand maladaptive behavior rather than judge and punish it and how a group therapist seeks to always accept the person but not all of the person’s behavior. In the authors’ experience, the psychological question can be therapeutically productive with noncompliant members, permitting them to honestly, directly, and briefly verbalize thoughts and feelings rather than act them out. The authors observe that asking paradoxical questions, particularly to those who avoid professional help, stimulates the verbalization of their pessimistic thoughts and feelings and diminishes their acting-out behaviors.

The leader then analyzes all responses written on the blackboard. Throughout, the leader praises and compliments the group for listening and answering the question honestly and briefly. The analysis section gives the leader an opportunity to demonstrate empathy, sensitivity, understanding, acceptance, and respect for the responses that have been received. The question in the example usually elicits members’ fears, doubts, and conflicts about receiving professional help and pres-
ents them with the challenge of accepting caring, supportive, nurturing relationships.

**Final questions and comments.** Time: 15 minutes. The leader always erases all responses from the blackboard before going to the final questions and comments, and then uses GAT to ask each member if they have any final question or comment regarding any aspect of the day’s session. Seeking to encourage honest, direct, and brief verbal communication between the leader and each member, the leader then comments and responds empathetically and supportively to members’ questions and comments while praising the entire group for their contributions to and cooperation with the group’s tasks. The final questions and comments systematically gives each member an opportunity to leave the session having had the last word. The authors always invite and encourage all members to make a verbal contribution. However, not all members comply with this request. When a member continues to respond with silence rather than accepting the option to pass by saying “pass,” this raises an assessment question. Is the member hearing impaired, distracted, or noncompliant (consultation with other treatment staff would be required). The leader supports the silent member by saying, “Each member always determines when he or she will speak, and it is better to be silent than false and dishonest.” If some other members appear uncomfortable with this member’s silent responses, the leader would then say, “Silent behavior for some of you may cause you to have feelings that you don’t want to have, but this is an opportunity for you to be more tolerant and accepting of others’ behavior and to cope with your unwanted feelings.” The leader always attends to and addresses significant nonverbal behavior.

**ADDITIONAL SUGGESTED PGC SESSIONS**

Topics selected for this specific client population are based on clinical observations and focus on acceptance of professional group treatment and problem-solving skills. The authors are in agreement with Spitz and Spitz (1999) and Monti et al. (1989), who view making a commitment to professional group treatment as an essential goal for chemically dependent clients, and that drug-free methods of coping with life’s issues and the development of problem-solving skills is an essential component of all chemical dependency treatment groups. The following topics, which the authors have repeatedly used in other PGC sessions, correspond with these clinical issues and reflect the range of intrapsychic and interpersonal goals previously cited earlier in this article.
They are how to stop using harmful chemicals; identifying what specific behaviors are needed for change; committing to group treatment and how to accept all available help to make change possible; trust/mistrust; fears related to group treatment; coping with temptations, rejection, criticism, separation, or loss; sexual relations; family; friendships; intimacy needs; identity issues; how to relax; and returning to school or employment.

Because many chemically dependent clients have severe difficulty in experiencing and expressing certain emotional states, learning to cope with the following emotions are necessary to maintain intrapsychic equilibrium and to function interpersonally (Monti et al., 1989; Spitz, 1999): fear/security, anxiety, anger, frustration/fulfillment, disappointment, sadness/happiness, helplessness, powerlessness, hopelessness/hopefulness, worthlessness/self-worth, jealousy, envy, guilt, shame, loneliness, isolation, and abandonment.

**DISCUSSION AND CONCLUSIONS**

PGC is a planned, 1-hour, open-ended, single-session workshop model that is conceived and conducted as a limited group process treatment while safely achieving limited but important psychotherapeutic goals. It has the advantage of being more inclusive, accepting, and accommodating than other professional group treatments while promoting the effects of Yalom's (1995) therapeutic factors, including instillation of hope, universality, imparting information, altruism, development of socializing techniques, and imitative behavior. Its limitations are that patients are not exposed to situations in which they can potentially learn to directly solve interpersonal conflicts and have corrective emotional experiences (Yalom, 1995), and they do not benefit from continuity of content from session to session. Also, a very small minority of patients unwilling and/or unable to tolerate the amount of control the PGC leader requests will tend to reject this group method.

Patients’ reactions to PGC are generally very positive. The overwhelming majority of members readily accept PGC’s structure and verbalize gratitude. At case conferences with other treatment staff, members who were described as silent in other group treatments were observed as willing and able to self-disclose in PGC. Members who use excessive verbalizing to reduce anxiety are usually able to tolerate the amount of control the leader is exerting, especially when they receive from the leader additional help as well as support and praise for their efforts to conform to the PGC norms. Those patients who believe that they can only benefit from more demanding group models of interper-
sonal learning and those very reluctant members who have a pattern of rejecting and/or prematurely terminating all treatment modalities express dissatisfaction with PGC.

Based on clinical observations, the authors conclude that PGC engages patients who are not ready for or who are reluctant to accept professional treatment. In Prochaska, DiClemente, and Norcross’s (1992) taxonomy, they are still in the precontemplation and contemplation stages of changing problem behaviors. Treating such patients as though they were ready and able to sustain dramatic (for them) behavioral changes potentially only sets them up for failure experiences that then could serve to decrease the likelihood of their future requests for and reliance on professional help. The authors propose that these issues might be applicable to other reluctant and high-risk client populations, for example, high school and college students (binge drinkers, illegal drug users, the potentially violent or suicidal) who are voluntary or have been mandated to receive counseling but who are uncommitted to attending their regularly scheduled group counseling treatments or unable or unwilling to tolerate the group counseling norms.

REFERENCES


College Students With Disabilities: An Access Employment Group

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This article provides an overview of the unique career and employment concerns of college students with disabilities and a group model to address these issues. Students' concerns include disclosure, self-advocacy, legal rights, reasonable accommodations, professional self-presentation, and establishing credibility. The access employment group is offered as a way to augment existing college career services for students with disabilities. This model helps students with disabilities successfully transition from academic to an employment setting.

The career development of postsecondary students with disabilities requires innovative service models (Thompson & Hutto, 1992). Some of the unique concerns of students with disabilities are disclosure, reasonable accommodations, and professional self-presentation (Lynch & Gussel, 1996; “We Ask You,” 1995). Underlying these concerns are establishing credibility and having strategies for putting interviewers at ease. Other concerns include asserting and knowing one's legal rights (e.g., Americans With Disabilities Act of 1990, [ADA]), anxiety about being accepted in the workplace, and understanding medical benefits. Some ways of addressing the above issues are structured education (through presentations, reading, lectures, or classes) and gaining experience through internships or cooperative education experiences. Group and individual instruction are popular ways of addressing the skill deficiencies in students who lack the ability to compete in their job search.

Self-concept and self-identity are two areas of career development that are often neglected (Blustein & Noumair, 1996). A glaring example of this is Babbitt & Burbach's (1990) findings that college students with disabilities may have high career aspirations but also have low expectations of what they believe is realistic to achieve. Students with disabilities are not sufficiently satisfied with their career development and do

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not feel encouraged to participate in interviews with employers (Schriner & Roessler, 1990). There is a paucity of group models that consider the self-efficacy, self-concept, and psychoeducation in the career development of students with disabilities (e.g., Zunker, 1994). This is unfortunate, considering that group participation is a well-documented source of empowerment for people with disabilities. Group participation has been shown to enhance self-esteem, self-advocacy, and coping skills (McWhirter, 1994).

Persons with disabilities, in particular, struggle as a minority group to compete with their peers in a culture in which the dominant group is often patronizing and ridicules people with disabilities (McWhirter, 1994). These attitudes lead to embedded constructs of self-doubt, self-blame, humiliation, anger, and depression (Holzbauer & Berven, 1996). Therefore, the development of a positive self-identity is particularly important for this population to overcome contextual barriers to their career choice (Lent, Brown, & Hackett, 2000).

Job support groups or clubs are one means of assistance. These group-clubs offer information and support to people who are job searching. The job club model provides an understanding of and ability to utilize job accommodations and work adjustment training and was used to develop the job support group specifically for people with acquired disabilities (Riordon & Kahnweiler, 1996). The access employment group (AEG) differs in that it does not focus on the job search but on career-related self-knowledge and insight to prepare for job-search activities. A job club or job support group would have activities such as résumé writing, résumé critiquing, and informational interviewing. All participants would typically follow the same activities in the same sequence, thus gaining the experience of going through it together.

In this article we describe a group model that combines support to enhance self-efficacy, empowerment, and education to build career-enhancing skills. In our experience, many college students feel left out and graduate without the skills to compete with their peers for appropriate jobs. Typically, these students struggle to find the courage to acknowledge their fears and self-doubts. They do not take the steps in self-exploration to enable them to begin job-search activities. Many of these students feel so far behind their peers in terms of career development that they become bewildered as to what to do next.

The group, cofacilitated by professional counselors familiar with disability issues, explores career issues that are intertwined with each group member’s self-concept and identity. The goal and expected outcome of the group (as a whole) is to prepare students for more traditional career development and exploration activities and experiences that are available on most college campuses. Therefore, the expected gains are
considered on an individual basis, but the goals are self-assessment and self-empowerment through group interactions. At the very least, students are expected to (a) participate in active discussions about disability and career issues, (b) develop and achieve a career-related goal within the time frame of the group sessions, and (c) develop a career development action plan. These activities provide students with increased self-efficacy and self-insight about themselves as professionals. The group also serves to assist students in the transition from college to work.

AEG

The AEG is specifically designed for college students who have little or no experience in marketing themselves as potential employees. Its focus is to inform, support, and educate in all areas related to employment and career development. This approach was created in response to the authors' observation that many students lack the information necessary to make appropriate academic major or career choices or appear stuck in making progress in the occupational arena they have selected and are being prepared to join. That is, students either lack sufficient information about themselves, about employment, or about the unique workplace challenges for persons with disabilities. They are at a disadvantage in completing their academic programs and finding satisfying employment after graduation.

Organizational Planning

Different campus agencies worked together to plan the group. For example, the counseling center career specialist and the disability center employment coordinator and staff developed materials and identified activities to be used with the participants. In addition, both the counseling center staff and the disability center staff recruited and informally screened potential group members.

In our groups, one facilitator (the disability center employment coordinator) was a graduate student in counseling and the other facilitator was a psychologist and career specialist from the campus counseling center. Based on our experience, we believe it was helpful that one of the facilitators, in this case the graduate student facilitator, had a disability. However, minimum qualifications to facilitate this type of group include group counseling skills and experience, knowledge of college student career development, and knowledge of disability-related issues and the ADA.
Recruitment and Screening

The most successful recruitment technique has been individual contact by the facilitators, including a telephone call to personally invite students to join. Students for our groups were also recruited from the campus disability center coordinators, and we posted flyers and distributed brochures at the career center, disability resource center, the student recreation center, and the college counseling center. Student referral from past group members is a particularly effective method of recruitment that we relied on for continuation of the group.

Criteria for inclusion that we used and recommend are that the enrolled student (a) has a documented disability, (b) is receiving or has requested reasonable accommodations for testing or the classroom, (c) has no neurological or psychiatric diagnosis that would interfere with the group process, (d) is informed of and agrees with the basic goals of the group, and (e) has not had successful employment with his or her current disability status. This last criterion may seem harsh, but it is important for all members to share common obstacles. If a student were able to be successful but simply wanted support or advice in the current market, she or he would be referred to a more appropriate activity (e.g., career services workshops).

Structure

The structure of the group is flexible to allow the students the maximum amount of time for decision making and problem solving. Some structural issues include size (i.e., number of participants), leadership, norms, location, open- or closed-ended membership, frequency, and duration of sessions. The ideal size of this type of group is 6 to 12 members. Less than 4 or 5 members puts a burden on existing members to be more active than they may wish to be and weakens the amount of support, feedback, interaction, and information sharing. More than 12 participants strains the facilitators to include everyone and resembles a class or support meeting rather than a working, skills-building, support group. It is best to have the group closed-ended unless the initial size of the group is so small that the benefits of infusing energy outweigh the cost of reestablishing norms and trust. If this is the case, then the group remains open for an additional specified time. At some point, however, the group is closed to ensure trust and bonding.

Ideally, it would be appropriate to have individualized groups for specific disabilities. However, in order to have enough members, disability types are usually combined. By combining disability groups, members increase their knowledge and awareness of their uniqueness and com-
monalties with others. It has also been beneficial for members to de-
scribe their disability to someone who is less threatening than a non-
disabled person, especially if this is a new experience. This also allows
students to practice disclosure.

**Format**

Using a combination of planned psychoeducational and experiential
activities, the AEG offers assistance in developing a satisfying and real-
istic career and life plan. Participants identify individual goals to be
accomplished through their work in the group. For example, a student
anticipating graduation may begin establishing a network in the busi-
ness community. Tailored activities include calling several representa-
tives from the business community and arranging an informational
interview. Another student with a serious mental illness can practice
opportunities with the other participants to improve verbal commu-
nication skills. The facilitators use handouts and homework activities for
the participants to complete between sessions and bring in the following
week for discussion. The themes for the weekly meetings generally focus
on the self-assessment component of the career planning process as well
as the various issues affecting people with disabilities in the workplace.

**SAMPLE 12-WEEK GROUP**

**Phase 1 (Weeks 1-4): Engagement**

The objectives of the first phase are numerous. First, facilitators
obtain informed consent. Then they must provide information (e.g.,
attendance, confidentiality, and participation) while establishing trust
and rapport. Reinforcement of participants’ goals and norms for group
are other Phase 1 objectives. Also, facilitators express their expectations
(members take ownership of group experience), generate commitment
to group, and begin to increase interpersonal communication skills and
enhance self-concept. The topics of individual sessions are used as
guidelines for structuring activities and homework. Topics during the
first 4 weeks include career development process, goal setting, intra-
personal experience of career and life planning (anxiety, fear, confusion),
identity formation, interpersonal skills (self-awareness, self-reflection,
self-monitoring), interpersonal skills (listening, assertiveness, feedback),
concept of work, and work attitudes. Some typical activities that
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correspond to the topics during the engagement phase are to provide ice-
breakers (e.g., 1-minute introduction of partner); identify, discuss, and
refine goals; provide basic stress reduction techniques; administer and discuss the Meyers Briggs Type Indicator, discuss and present lifeline, and discuss homework. Ideas for homework assignments are derived from the group sessions, but having some of the following assignments in mind may help generate ideas. Homework assignments we have used include bringing to group something that represents you as a metaphor, bringing to group your career development goal, practicing a new stress reduction technique, completing a lifeline, conducting a Studs Terkel-type interview, doing sentence completion activities, and monitoring self-talk.

Phase 2 (Weeks 5-10): Skill Building

Skill building is the longest phase of the group. The objectives include enhancing skills and strengths in the areas of intrapersonal skills (assessing and discovering one's abilities, strengths, values, goals, readiness, anxieties), interpersonal skills (communication, body language, assertion, self-advocacy, negotiating accommodations, problem solving, team building), and interactional skills related to community and environment. Topics can be intimidating to students, so extra time and attention should be given to the students' reactions and group dynamics. For example, some of our students had never requested an accommodation. Their parents and teachers had previously made the accommodation request for them. These students required more information about handling such requests and more time roleplaying and rehearsing accommodation requests. We also spent extra time providing helpful feedback from the group. Discrimination as a topic is important, but the session should not become an unproductive gripe session. Emotional self-management, skills required in career development process, goal setting, prioritizing values, conflict resolution, effective communication skills, decision making, identifying interests, career and leisure time, lifestyle choices, teamwork, and collaboration are additional topics that may be useful. Activities include using a skills checklist and having students tell others their observed strengths, having students tell others their own strengths; inviting a guest presenter to address the group on campus and/or community resources; providing materials on conflict resolution, effective communication, and assertiveness training; role-playing new skills (conflict resolution, self-advocating, requesting and negotiating reasonable accommodations, disclosure of disability); using structured activities that promote team building, discussing the significance of team playing in a work setting; and discussing homework. Discussion of homework may generate its own topic and should be given sufficient time to be processed. Homework during this phase may
include attending career fairs offered on campus or through community; conducting an informational interview or completing a job-shadowing experience; visiting the campus career development center; choosing a relaxation/stress buster to present or share with the group—it can be a story, a tape, candles, autogenics, jokes; journalizing about a time the member has discriminated against someone; attending an ADA workshop; or reading an assigned chapter from Bolles's (1998) *What Color Is Your Parachute?*

**Phase 3 (Weeks 10-12): Integration**

The final weeks’ objectives are to begin an integration of knowledge about self and the world of work. This includes enhancing group members’ ability to implement positive changes, understanding the process of change, committing to an action plan, and providing appropriate closure. Topics that promote these objectives include self-advocacy, coping with change, closure, good-byes, and future career moves. Activities that can be easily implemented are having members present to the group, asking members to share with the group how goals have been obtained or changed, providing more stress reduction techniques, and having members develop and present to the group their individual action plan. 

Homework should mostly be of a reinforcing nature. For example, students may be asked to practice their stress reduction techniques and, as a final assignment, (re)establish a support system for change and transition.

**DISCUSSION**

There are many theoretical and practical advantages, and some disadvantages, in providing these services in groups. It is well established (Ducey, 1989) that group techniques offer effective and efficient treatment of common academic and career difficulties for college students. In addition, group services create an atmosphere of learning, mutual support, and increased self-worth and self-esteem (intrapersonal, interpersonal) in a noncompetitive environment. Groups also have the advantage of promoting career maturation and an open exchange of information.

Further advantages of providing career-related group services that we observed (for students with disabilities) were fourfold. First, students can learn assertiveness skills. We particularly encouraged members to ask for what they need from the other group members as well as the facilitators. Second, students can learn social skills while they are
learning about career planning and their own path. Group participation is a well-documented source for empowering people with disabilities (McWhirter, 1994). When people have limited experience of finding that they can be of importance to others, their self-esteem is enhanced through the group experience (Yalom, 1985). Third, group participation can enhance self-esteem, self-advocacy, and coping skills. For example, students with acquired disabilities integrate their former conceptions of self with the realities of their current abilities and limitations that may not have been addressed in previous therapies or educative experiences. Individuals with a history of dissatisfactory experiences in important groups, for example, family, school, dominant culture group, can benefit because the group serves as a social microcosm. As time passes, members may recapitulate some of the negative experiences and redefine themselves (Yalom, 1985). Fourth, offering group interventions helps students with individuation and separation processes that are part of their developmental tasks (Ducey, 1989).

A limitation we found was the lack of hearing-impaired students, perhaps due to the fact that deaf culture defines deafness as a unique culture, exclusive of disability. Another disadvantage we found was that certain specific and remedial academic or career problems seemed better suited for individual counseling than group.

Other problems occurred because several of the participants as well as a cofacilitator used service dogs to assist them. Naturally, their dogs accompanied them to the campus and to the group. Although service dogs are socialized around other animals and trained to attenuate irrelevant stimuli, some of the dogs had occasional behavior problems. For example, some dogs were more protective of their owners and were easily threatened. Other dogs wanted to socialize with each other and their owners had to correct them. Sometimes the dogs were distracted by food or engaged in grooming behaviors that required a correction from their owners. As might be expected, those who did not use service dogs were more easily distracted by the animals’ presence. Group members who did use service dogs also appeared to be distracted by different handling styles (e.g., corrections and reinforcements).

Another difficult group dynamic centered on members’ disabilities (e.g., visible disabilities versus hidden disabilities). There were students with disabilities that were immediately apparent because they used a wheelchair or a cane. Other students (e.g., students with learning or psychiatric disabilities), however, appeared to be able bodied. As the group progressed, we became aware of interpersonal tensions among certain group members. Moreover, the interpersonal tensions were context specific: Students with hidden disabilities could choose non-
disclosure in their interactions with others, whereas those with disabilities that are observable do not have that option. Some participants whose disability was clearly evident questioned the legitimacy of including others whose disabilities were hidden and who were unable or reluctant to disclose the nature of their disability. Thus, there was an in-group/out-group dynamic that stratified the participants and, in some instances, may have determined who would join the group and who would not be welcome.

Additionally, members with progressive disabilities, (e.g., muscular dystrophy, multiple sclerosis) must consider an eventual decline in their abilities that not only affects their choice of career but the accommodations that will be needed as time passes. Those who have been disabled since birth and/or whose limitations are relatively stable would tend to have different views regarding the future and their place in it. Being able to orient oneself to the future is a prerequisite to effective career planning as well as hopefulness about one’s place in the future. Future facilitators should be sensitive to these issues and account for these differences in their preparations for the group. They should anticipate the intrapersonal responses to the various exercises and activities they use and the impact of these interventions on various career- and life-planning discussions.

One facilitator of our groups was disabled and one was not. This undoubtedly had an impact on the dynamics of the groups. For example, the members may have observed the interactions of the facilitators to determine how they might interact with nondisabled colleagues. The opportunity for vicarious learning was a benefit of this type of group over individual instruction or therapy.

Finally, there was a noticeable sexual tension between the male and female members of the group that affected the process. It was a type of playful experimentation with social interactions. Although we did not want to impede their social development, we occasionally redirected the group to focus on the topic at hand. Had this been a therapy group, many of the above-described group dynamics would have been brought into the here and now.

CONCLUSION

We have found that this group model assists students with disabilities in their career development. Outcome measures were very informal, consisting of verbal feedback during the final session as well as combined facilitators’ professional judgment of success. Typical positive
results included students’ changes in unrealistic expectations, increased self-awareness, enhanced interpersonal skills, and increased self-esteem and self-efficacy. In retrospect, an anonymous survey that queries individual outcomes and feedback would have been more useful and less biased. For example, we received no negative feedback and did not provide an anonymous outlet for that to occur.

The underlying premise guiding the design and facilitation of the group is that many students with disabilities struggle with negative or excessively restricted self-images to the extent that their career development is impeded and their choices are unnecessarily limited (Babbitt & Burbach, 1990; Blustein & Noumair, 1996; Holzbauer & Berven, 1996). Career counselors need to carefully assess relevant aspects of a student’s self-concept and ability to imagine functioning successfully in the world of work before attention is turned to more traditional self-assessment activities (e.g., exploring vocational interests, identifying salient work-related values). The AEG has been designed to provide such help.

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Providing Mental Health Services to Southeast Asian Adolescent Girls: Integration of a Primary Prevention Paradigm and Group Counseling

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Few writers have discussed the specific mental health needs of Southeast Asian adolescent girls. We present an intervention for Southeast Asian adolescent girls using a primary prevention paradigm within a culturally relevant framework consisting of (a) alcohol, tobacco, and other drug prevention; (b) tutoring; (c) cultural heritage classes; and (d) group counseling. Group counseling served as a catalyst to discuss issues raised from the other components of the intervention and provided an opportunity for participants to discuss personal, social, and academic concerns. The four goals were to facilitate (a) growth regarding self-acceptance, (b) learning strategies to cope with issues related to cultural identity, (c) a sense of trust among fellow group members, and (d) the application of what is learned in the group to everyday situations. Three implications are discussed: providing training on cultural and gender issues for facilitators, understanding cultural identity interaction theory, and using bilingual group leaders.

The population of America is becoming more diverse, and the need for counselors to develop culturally specific counseling strategies is profound. Developing culturally specific strategies is essential when focusing on the mental health needs of Asian and Pacific Island Americans, whose population is expected to grow at a higher rate than that of any other minority group in America (Aponte & Crouch, 1995).

Even though the Asian population is projected to increase, historically their utilization of mental health services is disproportionately low in relation to Whites and other minorities (Leong, 1986; D. W. Sue & Sue, 1999; S. Sue & Morishima, 1982). Recently, researchers have discussed the need to understand the mental health issues of Asian Americans in general and Southeast Asians specifically within a culturally relevant framework (e.g., Chung, 1994; Kitano & Maki, 1996; Leong, 1994; Nishio & Bilmes, 1998; S. Sue, Nakamura, Chung, & Yee-Bradbury, 1994).

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Although these researchers have added to our understanding of Asian Americans in a therapeutic context, their contributions have focused primarily on the mental health needs of adult Asian Americans. A need still exists to develop culturally relevant approaches when counseling Asian American adolescents in general, and Asian American adolescent girls in particular. Even though all youth, regardless of race or ethnic background, are vulnerable to substance abuse problems and academic problems, Schillinger and Chen (1995) suggested that Asian American adolescents might be more susceptible to these issues because of stressors related to language problems, intergenerational conflicts, and attempts to integrate new customs with old customs. All these concerns are related to the acculturation process or cultural identity development.

CULTURAL FACTORS

Acculturation

It has been postulated that one of the ways that cultural minority groups adapt to the dominant culture of American society is to develop a new cultural identity while attempting to maintain their own native cultural identity (Isajiw, 1990). Many theorists have referred to this process as cultural identity development or the acculturation process and have constructed models to conceptualize this process for minorities in general, (Atkinson, Morten, & D. W. Sue, 1998; Helms, 1995; Phinney, 1993) and Asian Americans (Kim, 1981; Sodowsky, Kwan, & Pannu, 1995). Kim (1981) postulated that the cultural identity process for Japanese American women included five stages. First, as children, Asian women identified with their native culture. Second, as they entered school age, they identified with the dominant culture to avoid overt and covert acts of discrimination based on being Asian. Third, Asian females discontinued identifying with the dominant culture and identified as members of an oppressed group. This led to alienation from the larger society. Fourth, Asian women reclaimed their Asian identity, immersed themselves in the Asian community, and developed anti-White attitudes. Finally, Asian women developed secure Asian identities and their anti-White attitudes dissipated.

Sodowsky et al. (1995) suggested that stage models such as Kim’s (1981) were too linear and did not reflect how cultural identity could vary across different situations for Asian Americans. Thus, Sodowsky et al. (1995) believed that the cultural identity of Asian Americans could be measured by assessing two dimensions of Asian American life: (a) the
degree of adoption of Whiteness and (b) the degree of retention of one’s Asianness. They suggested that cultural identity is a combination of yes and/or no answers to two questions: Is my cultural identity of value to be retained? Is the White identity of the U.S. dominant society to be sought? The first question measures one’s identity grounded in one’s own culture, or how one perceives oneself in the context of a shared cultural existence, values, and attachment with other Asian Americans. The second question measures one’s identity grounded in the culture of Western society and how one perceives oneself in the context of a shared cultural existence, values, and attachment to the dominant society (Sowdowsky et al., 1995).

Four ethnic identity orientations occur based on four combinations of yes and/or no responses to the two basic identity questions stated above:

- Yes and yes—Bicultural identity
- Yes and no—Strong ethnic identity
- No and yes—Strong Western identity
- No and no—Cultural marginalization

Sowdowsky et al. (1995) suggested that the four cultural identity orientations allow for a nonlinear trend over time and across situations and that the individual can move back and forth among the four orientations. This is in contrast to most models of cultural identity that suggest a linear development from a strong cultural identity orientation to biculturalism and then to a White identity orientation or vice versa.

**Gender Issues**

Although the cultural identity models take into account concerns related to acculturation, these models fail to explicitly address issues related to gender for Asian American women and girls. Bradshaw (1994) argued that cultural identity models fail to take into account Asian American females’ experiences of multiple oppression. Bradshaw charged that Asian American girls still face racist stereotypes of Asian women. For instance, she stated that the media in America projects images of Asian females as exotic, shy, submissive, and eager to please on one hand, and wily, manipulative, and untrustworthy on the other hand. Furthermore, Bradshaw added that many Asian cultures themselves devalue women and may relegate Asian females to an inferior status. Therefore, Asian American girls may face additional stressors related to gender that their male counterparts do not face. Thus, mental health interventions that target Asian American girls specifically are warranted.
In this article, we present an approach to meeting the mental health needs of Asian American adolescent girls with an emphasis on primary prevention and problem-solving/counseling groups. The primary prevention components focused on substance abuse, academic issues, and the maintenance of their native culture. These areas were identified as areas to which Southeast Asian adolescent girls were especially susceptible (Schillinger & Chen, 1995). The problem-solving/counseling groups focused on processing information from the preventative programs and addressing concerns of acculturation and cultural identity development. Acculturation and cultural identity were chosen because researchers in the area of multicultural counseling argue that these are important constructs in understanding how persons of color may respond differently to psychological and social issues based on the degree to which they identify with the dominant culture versus their native culture (Atkinson et al., 1998; Helms, 1995; Kim, 1981; Phinney, 1993; Sodowsky et al., 1995).

In the first section, we provide an overview of a primary prevention model as well as discuss the strategies derived from this model. In the second section, we discuss the group counseling intervention. In the final section, we present some implications for counselors working with Southeast Asian adolescent girls.

**PRIMARY PREVENTION**

In general, in this country Asian Americans have struggled to obtain appropriate mental health services. Alternatives such as primary prevention have been proposed to manage the distinct mental health needs of Asian Americans (Owan, 1985). Primary prevention is defined as an intervention that promotes psychological health and forestalls the development of psychological disorders (Owan, 1985). We advocate implementing a primary prevention paradigm with Asian Americans because it works best in a group setting, it relies on problem solving as a form of intervention, and it does not require an insight-oriented perspective. These characteristics of the primary prevention paradigm are consistent with culturally specific strategies for counseling Asian Americans. For instance, the group orientation of primary prevention parallels the collectivistic nature of Asian American culture (Ho, 1995; D.W. Sue & Sue, 1999). Furthermore, problem-solving techniques are strategies that are consistent with traditional Asian culture (Root, 1998). Similarly, deemphasizing insight-oriented techniques is a commonly recommended guideline in working with Asian Americans (Owan, 1985; Root, 1998; D.W. Sue & Sue, 1999).
In his model of primary prevention for Southeast Asians, Owan (1985) theorized that there are three units that affect the individual to facilitate improved mental health and coping skills. These are the personal unit, the social unit, and the institutional unit.

The personal unit consists of the extended family and friendship networks. Owan pointed out that due to Southeast Asians’ reliance on family and friends, it is important to include both groups in any type of program or event. Fraternal organizations, neighbors, and mutual/self-help groups characterized the social unit. This unit brings together Southeast Asians who help one another endure concerns related to acculturative stress. Finally, the institutional unit is made up of health and mental health delivery systems, voluntary agencies, schools, and churches.

The focus of our intervention was on the social support unit. We believe that this unit acts as the mediator between the personal and the institutional units. Although each unit continues to have an impact on the individual, we hypothesized that utilizing the social unit as the intermediary strengthens the association between the personal unit and the institutional unit.

The strengthening of this association between the two units is accomplished by the use of mutual assistance associations (MAAs). MAAs provide culturally or ethnically similar individuals who are more acculturated to assist with providing coping skills to achieve the ultimate goal of improved mental health. We believe that this cultural matching is an essential element to the success of the social support unit affecting the individual. The Community Empowerment Project (CEP) of Akron, Ohio served as the MAA for our preventive paradigm.

**Strategies Based on the Prevention Paradigm**

Our prevention paradigm consisted of four different components. These were alcohol, tobacco, and other drugs prevention program (ATOD), cultural heritage classes, tutoring twice a week, and group counseling. The ATOD prevention program utilized drug specialists and bicultural educators to provide direct drug prevention education. The cultural heritage classes were conducted separately for each ethnicity (Hmong, Vietnamese, and Laotian) in recognition of intragroup differences among Asian Americans (Kitano & Maki, 1996; D. W. Sue & Sue, 1999). The goals of the cultural heritage classes were twofold. First, the cultural heritage classes provided support for the development and maintenance of the participants’ cultural identity. Second, the cultural heritage classes provided assistance with managing issues related to acculturation. Specifically, the class provided participants with the
skills to adapt to the norms of an unfamiliar culture. We maintain that cultural heritage classes are one way to facilitate the development of cultural identity and manage concerns related to the acculturation process. The final component was the group counseling intervention. This intervention served as a catalyst to problem solve from the three other components. In addition, the group counseling component provided an opportunity for participants to discuss other personal, social, and academic issues.

GROUP INTERVENTION

Selection of Group Members

The director of a community-based outreach program for Asian Americans selected participants based on a list of students who stated that they were interested in the programs offered by the agency. Once students were selected, parents were contacted and informed of the group topics, notified of the videotaping of sessions, and were asked to sign consent forms before commencement of the first session.

Group Leader Characteristics

The group leaders were two Caucasian master’s-level graduate students. One was a man, age 31, the other was a woman, age 28. Each had several years of experience and training in the group process and each had interests and experience working with Asian Americans. Although there are mixed findings related to ethnic clients’ preferences for the ethnic background of their therapists (Han & Vasquez, 2000), due to therapist availability, having an Asian counselor facilitate the group was not an option for this project. We do believe, however, that the cultural credibility of non-Asian counselors can be increased through the association with the MAA, which by design consists of Asian Americans. In addition to a relationship with the MAA, it is important for the group leaders to possess cultural knowledge and self-awareness. Possessing cultural knowledge and self-awareness allows the group leaders to be culturally sensitive in three areas. First, in the didactic instruction components of the group, it allows the group leaders to select and present material in a culturally sensitive manner. Second, possessing cultural knowledge and self-awareness allows the group leaders to consider group members’ interactions in a culturally relevant manner. For instance, during the initial session the participants were very reluctant to interact. In addition to the group leaders recognizing that this was a
characteristic of the initial phase of group, the lack of interaction also was considered to be related to language barriers and to the fact that group counseling can be considered a cross-cultural experience for Asian Americans because discussing personal issues and discussing feelings outside of the family is not consistent with traditional Asian culture norms (Han & Vasquez, 2000). Thus, the group leaders raised all three issues with the participants. Third, possessing cultural knowledge and self-awareness allows the group leaders to consider how the leaders’ cultural biases may influence the group process. For example, the group leaders may choose to ignore relevant culture information, fear culture conflict, or project an ethnocentric bias into the group process. In essence, it is argued here that the group leaders’ own cultural identities are relevant leader characteristics. Moreover, it is argued that the more highly developed the cultural identity of the group leaders, the more likely the group leaders can facilitate growth in the cultural development of the participants.

Group Composition

The group intervention was implemented as an after-school program and consisted of 15 female adolescents ranging in age from 11 to 15. The participants were separated into Group I (n = 8) and Group II (n = 7). Selection of members for the two groups was based on two factors. Participants who were considered less acculturated and less proficient with the English language were placed in Group I. Participants who were more acculturated and more proficient with the English language were placed in Group II. Homogeneous groups were formed on the acculturation variable, because homogeneous groups are perceived as having less conflict, being more cohesive, providing more support, and being better attended (Johnson & Johnson, 1994; Yalom, 1985). Moreover, Kitano (1989) reported more positive outcomes with Asian Americans when group composition was homogeneous. Level of acculturation was determined based on the results of the Cultural Identity Survey. The Cultural Identity Survey is a six-item survey developed for this project to measure the cultural identity of the participants (see the appendix). No reliability or validity estimates exist for this scale. Persons who answered d or e to Items 4 through 6 were considered less acculturated. Persons who answered a, b, or c on Items 4 through 6 were considered more acculturated.

The ethnic makeup of Group I consisted of 5 Vietnamese, 2 Hmong, and 1 Lao. Group II consisted of 3 Vietnamese, 3 Hmong, and 1 Lao. For both groups, time in the United States ranged from 8 months to 13 years
(2 of the participants were born in the States). Although several of the girls were proficient in English, there were 3 new arrivals who had limited exposure to English, having been in America for only 8 to 10 months.

On a self-report intake questionnaire, which utilized a Likert-type scale rating of language proficiency from 1 (not good) to 5, the group members rated their fluency at 2.36. Other intake items asked for name, age, gender, insurance, number of persons living in the household, ethnic background, source of referral, last contact with a health care system, household income, and other services used. We utilized two approaches to manage the language barrier. For the first part of the group sessions (3 weeks), an employee from CEP translated for the nonproficient speakers. For the second half, group members who were more proficient in the English language provided peer translations. The findings of the first 3-week period of our group sessions were consistent with the findings of Tsui and Sammons (1988). They found that interpreters lacked clinical skills and impeded the progress of the interactions among group members. However, during the final 3 weeks using group members as interpreters there was a significant increase in interactions among participants, and there was a significant increase in the emotional content of topics presented.

**Group Goals**

There were four group goals. The first goal was to increase participants’ self-awareness and self-acceptance. According to Kim (1981), Asians Americans may reject their own Asian identity and identify with the dominant culture to avoid acts of discrimination. Our goal was to maintain and develop their Asian identity to increase self-acceptance, including those aspects of self that were being targeted for discrimination. The second goal was to develop constructive strategies to cope with issues related to cultural identity. The emphasis here was on developing strategies to cope with learning new cultural customs without devaluing their native customs and beliefs. The third goal was to develop a sense of trust among fellow group members to serve as sources of support for each other. At times, students of color can find it difficult to fit into the dominant culture. Developing a cadre of support persons can reduce the stress of trying to fit into the dominant culture. The fourth goal was for participants to develop coping strategies for personal, social, and cultural stressors and apply these strategies to everyday situations.
Summary of Group Sessions

Session 1. Most of the time allotted to this session was spent discussing confidentiality, group rules, informed consent and assent, and group topics. Although most of the girls knew each other prior to the formation of the group, some time was spent on introduction of group members. Next, the group leaders outlined expectations of group members. These expectations for group members included attending sessions on time, expressing their thoughts and feelings in an open and honest manner, sharing concerns with the group, deciding how much they wanted to share each week, respecting each other, and applying what they learned in group to everyday situations. Finally, the interpreter was introduced and her role was discussed. The participants were informed that the interpreter would be available for the first three sessions and group members would interpret for the final three sessions. During this session, the group leaders did most of the talking and had to be directive most of the session by asking specific questions. Moreover, the group leaders asked specific individual members questions in relation to the degree to which they understood the expectations for the group. The group leaders also talked about how being in group may be a cross-cultural experience for participants and encouraged members to discuss this cross-cultural experience and the language barriers that they may be experiencing. At this point in the development of the group, participants did not discuss their reactions to participating in a group as being a cross-cultural interaction. There were several adaptations that the group leaders needed to make. First and foremost was managing the delay in communication due to translation. Moreover, at times during this session it was unclear if the silence on the part of the participants was due to the language barrier, the cross-cultural experience of being in a group, or due to the fact that it was a newly formed group, as all three factors seemed to be operating. To compensate for these factors, the group leaders at times had to repeat the same information in different ways and provide concrete examples when appropriate.

Sessions 2 and 3. The topics for these two sessions were cultural identity and cultural differences. Each of these sessions commenced with a discussion of group roles and expectations followed by an icebreaker. The icebreaker for Session 2 required each member to select the first letter of her name and choose a word that begins with the same letter that also describes the person. The goal of the exercise was to have members share something personal with the rest of the group. The icebreaker for the second session required each member to share one thing she had learned about another member of the group. For all the sessions, ice-
breakers did not facilitate a lot of sharing among group members. In Session 2, the group leaders discussed differences between the leader and group members, leading to a discussion of cultural differences and racial discrimination. The topical focus for both groups centered on issues associated with cultural identity development and issues related to the acculturation process and prejudice. Group members described their experiences, most of which took place at school. These experiences centered on being called racial epithets that were based on stereotypical Asian physical characteristics. For example, group members recounted being called “chink,” “slant-eye,” and “gook” by their classmates. Processing these encounters led to discussions of group members’ thoughts, feelings, and ways to cope with prejudice. Many of the group members discussed the challenge of trying to fit in with their White classmates. In fact, some participants talked about wanting to minimize the importance of their cultural identity. This seemed to parallel the second stage of the Kim (1981) model. Other group members discussed coping with discrimination by reminding themselves of their uniqueness and being proud of it, interacting with others who accepted them, and ignoring racial comments, or reporting the comments to the appropriate authorities. Discussion of this topic required that the group leaders felt comfortable discussing racial discrimination without becoming defensive. This was especially important due to the fact that perpetrators of these offenses were the same race as the group facilitators. This suggests that group leaders with less developed racial identities may experience more difficulty approaching such topics and may experience difficulty facilitating a discussion among group members. In fact, group leaders whose racial identities are less developed may even deny the importance of discrimination or deny that discrimination even exists.

Participants also discussed parents’ roles and how these roles differ from the roles of their American friends’ parents. Finally, participants discussed the roles of their siblings and how boys received different treatment than the girls received. Understanding cultural identity and how it affects the acculturation process was a key element to understanding the within-group differences among group members. Furthermore, length of time spent in this country was related to level of acculturation. Adolescents involved in our intervention who had been in this country for more than 2 years had dissimilar concerns than those of the new arrivals. The more acculturated girls (Group II) described issues that are consistent with what we would expect from same-age peers born in America, regardless of culture. For example, the more acculturated adolescents wanted to address concerns related to boys as opposed to the new arrivals, who were more concerned about issues related to country of origin and their families.
Another concern presented by the more acculturated girls was the issue of preferential treatment of male children within the family. For instance, the girls reported being given more chores at home than their male siblings were given. As a result of being immersed in the dominant culture of the United States, Southeast Asian Americans were exposed to more egalitarian gender roles outside of the family unit. We discern that this interaction may have prompted their feelings of unfair treatment within their own family structure. Discussion of this topic required that the group leaders have knowledge of the cultural norms of the family structure within some Asian families. Moreover, it was important for the group leaders to be cognizant of the potential alienation that could occur between the families and the participants. Thus, it was important for the group leaders to facilitate a discussion of differences between family structures and roles without stating or implying that the Euro-American family structure and roles were better than Asian American family structure and roles.

Session 4. The group leaders began this session with an icebreaker, followed by a discussion of violence in schools. The icebreaker required the participants to report one thing that they had learned in the group. Participants recounted incidents of violence that they had either witnessed or endured themselves. Most of the incidents reported were fights between individuals or students being hit. The group leaders facilitated a discussion on ways to handle potentially violent situations. The strategies included staying away from peers who had reputations for fighting; reporting acts of violence to parents, teachers, or the principal; and learning to walk away from potentially volatile situations.

Session 5. The group leaders opened with an icebreaker. Participants were asked to focus on one thing that stood out for them from the previous session. The focus of this session was to link all the topics together. Group members discussed managing prejudice and discrimination, processed feelings related to the differences in treatment between boys and girls, and addressed issues related to acculturation. Most of the participants discussed how it was helpful to hear that some of their peers were struggling with some of the same issues of trying to make sense of who they were and trying fit in at home, at schools, and in their neighborhoods. It was important for the group leaders to facilitate an acceptance of where each person was regarding identity development by modeling acceptance.

Session 6. The focus of the final session was on processing the experience of being in a group. Most members talked about how reluctant they
were to be the first one to talk. Others discussed how helpful some of the problem-solving strategies were. In fact, several commented that several of the solutions seemed simple once a person had time to step back and reflect on the situations. The group leaders also provided a questionnaire for participants to complete to evaluate the group sessions.

EVALUATION OF THE GROUP
ASSESSMENT OF GOALS ACHIEVED

There were four goals developed for this program. These were related to increasing self-acceptance, learning to cope with issues related to cultural identity, developing trust among group members, and learning to generalize strategies to the real world that were discussed within the group. No participants reported feeling better about who they were as it relates to general self-esteem. No formal assessment was completed using instruments that assess self-esteem. Regarding the second goal, however, participants reported feeling better about their cultural identity and their families’ heritage after having participated in the discussions related to these topics. We believe that an increase in feeling better about their cultural identity and their families indirectly affects their self-esteem and self-acceptance in a positive manner, due to the fact that for some traditional Asian families, individual self-esteem and self-acceptance and feelings toward the family are not easily distinguishable (D. W. Sue & Sue, 1999). Participants honestly and openly discussed concerns of a personal nature, suggesting that there was a high level of trust and support among members. In fact, one group member commented, “I felt comfortable because everything stays in the group.” Regarding the last goal, participants discussed how they could appropriately manage violent situations outside of the group. For instance, members discussed identifying adults who could be contacted such as parents, teachers, the principal, and the police. A six-item questionnaire was employed and consisted of both open- and closed-ended questions to obtain information. The four questions were Likert-type questions to which the participants were asked to respond on a scale ranging from 1 (not satisfied) to 5 (very satisfied). The first question asked members if they were satisfied with the content of the group. The second question asked members if they were satisfied with the activities of the group. The third question asked members if they were satisfied with the group leader. The fourth question asked members about their general level of satisfaction with the group. The fifth question asked if they would participate in programs again and if so, what topics would they like to see covered. The sixth question asked participants to make any comments about the
group. Overall, the group members indicated that they were satisfied with their involvement in the group and that they would be interested in future groups. All participants marked 5 for satisfaction across items. Thus, we were unsure of how critical they were willing to be of the project. For the open-ended questions, group members noted that topics discussed were of interest. In particular, group members indicated that discussions that focused on issues related to culture interested them the most. The topic of dealing with violence was also of particular interest. This is probably a result of going to schools where acts of violence are frequent. As for activities, members noted that they were satisfied but would have liked to attend field trips as a group. The types of trips were not specified.

LIMITATIONS

There were several limitations of this project. First, the length of the program was only 6 weeks. Although some changes were observed, it is assumed that an increase in the length of the group program would lead to more changes. Second, the lack of bilingual group leaders may have slowed down the development of group dynamics and group cohesion. Third, the lack of administration of standardized assessment procedures limits any conclusions that can be made about the participants’ self-esteem or cultural identity development. Moreover, although the utilization of some open-ended questions provided some in-depth responses, this format also presented its share of difficulties. For instance, open-ended questions that were less concrete led to some interpretation difficulties for some group members for whom English was a second language. Third, no follow-up of the participants was implemented, which prohibits determining if changes observed will be stable over time.

Implications for Group Counseling Programs

One of the primary implications of this description of group work with Asian American adolescent girls is the need for clinicians to be aware of gender issues, cultural identity development, and issues related to the acculturation process. For instance, gender issues and the disparity of treatment between Asian American boys and girls were central for highly acculturated Asian American adolescents. Family, culture, and country of origin were central for less acculturated group members. Thus, the extent to which gender issues were salient was directly related to the acculturation level of group members.
Another implication of this report on group work with Asian American adolescents is that it is necessary for group leaders to be aware of their own level of cultural identity development, especially group leaders who are members of the dominant culture (see D. W. Sue & Sue, 1999, for a review of cultural identity models). Group leaders need to understand how their own level of cultural identity development might interact with the cultural identity development of their group members. This topic was relevant as the issues of racial discrimination and family and cultural norms were discussed. It may be easy for group leaders to assume that values such as familial piety are less relevant than assertiveness and independence. Helms's (1994) cultural identity interaction theory provides a conceptual framework for understanding how the level of cultural identity of the group members and the group leaders' level of cultural identity may interact. She posited three types of relationships. These were parallel relationship, regressive relationship, and progressive relationship. A parallel relationship refers to the facilitator and the group member in the interaction being at the same stage of cultural identity development if they are of the same culture. If the facilitator and the group member are of different cultures, they are at analogous stages of cultural identity development. Helms posited that this type of interaction does not lead to further identity development by a group member because the facilitator does not yet have a more advanced understanding of cultural concerns. Thus, it is unlikely that a facilitator's articulation of cultural matters can lead to a more complex understanding of culture by the group member.

A regressive relationship refers to a facilitator having less developed cultural identity attitudes than a group member. According to Helms, this type of relationship results in varying degrees of disharmony, conflict, tension, and rebellion because the facilitator is less comfortable than the group member in discussing cultural topics. Therefore, the group member may resort to less desirable behaviors to manage the discomfort in the relationship. Similarly, the facilitator may consciously or unconsciously coerce the group member to think about culture in a manner similar to the facilitator.

A progressive relationship refers to the facilitator being more advanced than the group member as relates to cultural identity development. Helms suggested that this type of relationship leads to further identity development in the group member because the facilitator can offer experiences and creative role modeling that will be helpful to the group member's cultural identity development. Although Helms offers no prescription for group leaders who find themselves in a parallel or regressive relationship, implicit in her theory is that group leaders, at a
minimum, need to be open to self-exploration as it relates to their level of cultural identity development.

A third implication is the topic of bilingual facilitators. A limitation of our program is that we do not have bilingual facilitators. Thus, we initially relied on interpreters and subsequently relied on group members who were bilingual. As discussed earlier, each strategy had its own limitations that could be eliminated by using bilingual facilitators. Furthermore, there is some evidence that suggests that bilingual therapists contribute to a better therapeutic outcome. For instance, Flaskerud (1986, 1991) found that clients who were matched with therapists on the basis of language and ethnicity were less likely to drop out of therapy than clients who were not matched on the basis of language and ethnicity.

In summary, although theorists and researchers prescribe culturally appropriate guidelines for working with Asian Americans in general, few writers discuss guidelines for Southeast Asian adolescent girls. We described an approach to providing mental health services to Southeast Asian adolescent girls using a primary prevention paradigm and group counseling. Group members reported being satisfied with the group, and changes were observed in participants. However, no long-term follow-up was included as a part of the assessment process to determine if changes observed were stable over time. Several limitations of the project were described. Implications for group leaders include understanding acculturation and cultural identity issues and understanding cultural identity interaction theory.

APPENDIX
Cultural Identity Survey

Please circle the letter that corresponds with your answer.

1. How would you describe yourself if someone were to ask you: What are you?
   a. Laotian, Hmong, or Vietnamese
   b. Asian or Asian American
   c. Eurasian or Amerasian
   d. American
   e. Other

2. How do you feel when you are asked, What are you?
3. With what group do you feel most comfortable?
   a. Laotian, Hmong, Vietnamese
   b. Caucasians
   c. Americans
   d. Other

4. How important is your cultural or ethnic identity in your life?
   a. Not important
   b. A little important
   c. Somewhat important
   d. Important
   e. Very important

5. How often does your cultural or ethnic identity affect your life?
   a. Never
   b. Almost never
   c. Sometimes
   d. Most of the time
   e. Almost always

6. How important do you believe it is to maintain your cultural roots?
   a. Not important
   b. A little important
   c. Somewhat important
   d. Important
   e. Very important

REFERENCES


Talking Circles:
Listen, or Your Tongue
Will Make You Deaf

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The purpose of this article is to provide a description of the Native American talking circle in terms of (a) its group structure and process, (b) selected examples and descriptions of group incidents to illustrate the process, and (c) qualitative findings based on group member comments that support the group’s development of sense of community and members’ listening and empathy skills. Although the talking circle process presented here is based on a peer education program with college-level students, we nevertheless believe its adaptation and generalization to other populations and contexts are possible and worthwhile.

The purpose of this article is multidimensional in that it is intended to inform group practitioners of a Native American practice—the talking circle. We believe the talking circle is adaptable to group work in innovative, multiculturally informative, and useful ways not only by providing a group work structure and process that address the building of a sense of community among a group but also by developing group members’ skills in listening and empathy. This is accomplished through the use of Native American traditions and rituals and by focusing on understanding and building community as well as members’ common attitudes, beliefs, and feelings rather than their differences.

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The talking circle would most appropriately fit within the psycho-
educational group type (Association for Specialists in Group Work,
1992), although aspects of its unique format, as mentioned, have been
adapted from Native American rituals and traditions (Colmant &
Merta, 1999; J. Garrett & Garrett, 1996; M. Garrett, 1998a, 1998b;
Wilbur, 1999a, 1999b). The idea of talking circles emerged from the
Cherokee tradition of Donelawega, building community through the life
of the circle (M. Garrett, 1998a, 1998b). The circle of a traditional
Donelawega, in Cherokee, simply means “a coming together of people
for a special purpose [powwow]” (M. Garrett, 1998b, p. 65). Although
the powwow originated with the Plains tribes, Native people across the
United States have embraced the powwow as a pan-Indian tradition
that brings people together for a special purpose to be carried out
communally.

Similarly, Native Americans have long used the circle to celebrate
the sacred interrelationship we all share with one another. The ceremo-
nial circle, in particular, has served as a sacred function through the ritual
healing or cleansing of the body, mind, and spirit. It also serves as a way
to bring people together and as a forum for participants’ expression of
thoughts and feelings in a context of complete acceptance, ensuring that
relationships are conducted in a respectful manner.

In addition to the obvious connection of the traditional and ceremo-
nial Native American circle to group work, this article focuses on college
students involved in a peer education program as the example and case
study for the application of talking circles to group practice. More specif-
ically, the talking circle and its associated rituals were used with under-
graduate peer educators (interns) in the development of the peer groups’
sense of community and members’ empathy and listening skills.

Thus, the purpose of this article is to provide a description of the talk-
ing circle in terms of (a) its group structure and process, (b) selected
examples and descriptions of group incidents to illustrate the process,
and (c) qualitative findings based on group member comments that sup-
port, similar to the findings of Rucklos Hampton and Norman (1997),
the peer groups’ development of sense of community and members’ lis-
tening and empathy skills.

SETTING, PARTICIPANTS, AND LEADERS

Setting

Talking circles were implemented with college-level students
involved as peer educators-interns in a comprehensive alcohol and other
drug prevention center (known as the HEART Program) at the University of Connecticut during the spring semester of 1999 as one among many educational and intervention programs offered. The HEART Program has been nationally recognized by *Promising Practices* (Center for the Advancement of Public Health, 1997, 1998) as one of the nation’s top 10 comprehensive, college-level alcohol and other drug programs for its unique, innovative, and effective educational, prevention, and intervention programs.1

**Talking Circle Participants**

Participants in the talking circles consisted of heterogeneous groups of undergraduate peer educators who were completing internships with the HEART Program. Each semester, undergraduate students across campus may choose to participate as HEART Program peer educators in one of three internship categories. Peer educators in the category of academic interns received 3 to 6 hours of credit from their respective academic departments for their involvement, whereas work-study interns received financial aid monies, and volunteer interns received community service hours for their participation in the program. Again, the talking circle was an educational program provided to peer educators-interns in the development of the groups’ sense of community and members’ empathy and listening skills.

The participants in this example were self-selected and voluntarily chose to be members of a talking circle from the numerous educational, prevention, and intervention program components offered by the Heart Program. These choices were available to peer educators completing internships during spring semester 1999 (13 different options) and included individual counseling, training sessions, clinical team, educational team, research team, HEART House team, and talking circle.

Participants’ choice of membership in a particular talking circle was determined by the time of day or evening the particular circle was scheduled. There were six talking circle groups offered and facilitated during spring semester 1999. Each circle consisted of 6 to 10 group members who met as a group from 9 to 11 times during the semester. There were 44 total students who participated in the six talking circles during spring semester 1999. Their ages ranged from 18 to 34 years old (mean = 20.15, SD = 3.39). Their racial composition included Caucasian (n = 29, 66%), African American (n = 4, 9%), Latino/Latina (n = 4, 9%), West Indian (n = 5, 11%), Asian American (n = 2, 5%) (mean = 8.8, SD = 11.34). There were 13 men (30%) and 31 women (70%) (mean = 22, SD = 12.72).
Leaders

In addition to the undergraduate student interns, eight graduate students in counseling and clinical psychology also completed internships with the HEART Program during spring semester 1999. Leaders of the talking circles thus consisted of five graduate students in counseling and clinical psychology from the University of Connecticut and the University of Hartford and the HEART Program coordinator. All group leaders were Caucasian, except one female Ph.D. student who was Taiwanese. Their ages ranged from 22 to 32 years old (mean = 25.6, SD = 3.91), excluding the female program coordinator who is 58 years old, a licensed psychologist, holds a Ph.D. in counseling psychology, and has 28 years experience as a therapist, group leader, and counselor educator. The program coordinator also functioned as a circle leader and as the clinical supervisor of the other group leaders.

GROUP STRUCTURE AND PROCESS

Group Structure

For Native Americans the circle symbolizes an entire approach to life. The Native American regards the circle as the principal symbol for understanding life’s mysteries; it is impressed throughout nature. Humans look on the physical world through the eye, which is circular. The earth is round, as are the moon, the sun, and the planets. The rising and setting of the sun follows a circular motion; the seasons form a circle. Birds build their nests in circles; animals mark their territories in circles. Traditionally, tribes lived in circular homes, and their communities were arranged in circles. To Native Americans, the whole of life appears in circular patterns. By honoring the circle, we honor the process of life and growth. Similarly, traditional Native Americans have always believed that healing and transformation should take place in the presence of the group, because we are all related in very basic ways and can benefit from the support and insight of others. Each person comes to the circle with his or her own concerns, and together, participants seek harmony and balance by sharing stories, talking, and sometimes just sitting together in silence. The circle is a sacred reminder of the interrelationship, respect, and clarity that come from the wisdom offered by one’s experiences, the experiences of others, and the world in which we live.

More specifically, the talking circle fulfills an important purpose by ensuring that relations are conducted in a very respectful manner. It
traditionally serves as a forum and structure for the expression of 
thoughts and feelings spoken from the heart in a context of complete 
acceptance, belonging, and comfort by participants.

These simple Native American concepts and philosophy served as the 
basis and structure for developing and implementing talking circles in 
the setting of a college alcohol and other drug prevention center. Talking 
circles were a place and process in which students could connect with 
each other, a safe place where students could talk about life matters that 
were important to them (matters of the heart), and a place and process 
in which they could practice empathy and listening skills. The focus of 
the circles was on understanding and building community through 
members’ common attitudes, beliefs, and feelings rather than their dif-
fferences and conflicts. Ending each talking circle group with members 
standing in a circle, holding hands, and each group member saying, 
aloud, “Donelawega,” was one of the group rituals (structures) utilized to 
emphasize this group goal and theme.

Additional group structure and rituals were likewise used in the talk-
ing circles to ensure and promote group members’ empathy and listen-
ing skills, their understanding and community building, and the atti-
tudes, beliefs, and feelings they shared.

The burden basket. One such structure and ritual was the use of a bur-
den basket in the talking circles, adopted from its Apache heritage and 
tradition. A burden basket is an ornately handwoven basket of various 
sizes typically hung at the outside door or entrance to one’s home. Prior 
to entering their home or the homes of their friends and relatives, the 
Apache Indians symbolically placed their burdens into the basket so 
these concerns would not disrupt the harmony and balance of their 
homes and their interactions and relationships with family, friends, and 
loved ones.

In the context of talking circles, a house burden basket was hung out-
side the door of the program coordinator’s office. During the first talking 
circle meeting, each talking circle member was asked to provide an 
amonymous, handwritten “burden,” or secret, which was then typewrit-
ten to further preserve anonymity and placed into the burden basket. 
Talking circle members were also informed of the anonymity and confi-
dentiality of their secrets or burdens, and anyone participating in the 
HEART Program in any manner was permitted and encouraged to place 
their burden or secret into the basket. The burden basket and its con-
tents were respected by all and never violated in any way.

The secrets placed in the burden basket were then used by all talking 
circles by drawing a secret from the basket and using that secret as the 
topic or issue for the group’s discussion. The goal of the discussion was to
promote and develop group members’ ability and willingness to listen, to understand, and to empathize with each other rather than to provide advice, judgment, criticism, or argument.

The talking stick. To ensure the conditions of respect, acceptance, belonging, comfort, and safety and to promote a place and process in which group members could practice empathy, listening skills, understanding, and community building, another Native American tradition and ritual was used: the talking stick (see Baldwin, 1994). In the circle, a specially chosen object, frequently a talking stick, is passed around, and each person, in turn, speaks her or his truth. A talking stick embodies the wisdom-heart of the group, and it is often an artifact of great beauty, simplicity, or significance. The talking stick spiritually empowers its holder to speak his or her heart-truth as an offering to the group. The talking stick is an object that represents truth and understanding, both of which are powerful agents of healing in Native American tradition.

Traditionally, among many Native American tribes and clans the talking stick is used during council meetings to discuss important issues or concerns peacefully by speaking from the heart and by listening intently to what others have to say. The talking stick may be literally a stick or a small branch cut from a tree, about an inch in diameter and 12 inches long. It may have carvings or be decorated with feathers, rawhide, turquoise stones, or painted fetishes, or it may be just a plain stick. Regardless of its beauty, significance, or simplicity, the stick serves as an invitation and encouragement to speak from the most undefended place in one’s self. Three rules apply to the talking stick: Speak honestly and truthfully from the heart, be brief, and listen attentively with respect.

As a community-building exercise at the beginning of talking circles, some group leaders have the entire group go on a small field trip to select their own talking stick for use in their circle. They find the tree they want to use, cut from it a small branch, and then design and decorate their stick for use in the circle. It is also important to note that within Native American culture, something is always left in thanks for anything taken from nature—a pine cone, a rock, tobacco, a feather. Therefore, the group should always leave some object near the tree when they select and cut their stick from a branch.

Within the talking circle, a group member may speak only when he or she is holding the talking stick, and group members must wait their turn to speak until the talking stick is passed to them by another group member or the leader. There may be times, however, when the stick is not passed around the circle. Instead, it is placed in the center of the circle after a group member has spoken and picked up from the circle’s center when another group member is moved to speak. Again, this ritual
and structure ensures peaceful and attentive listening by group members and respect for the speaker. In this way, group members may speak without concern that they will be interrupted, criticized, or judged. The process is not one of making strong arguments for or against something or convincing one another of right or wrong. It is a process of becoming still and quiet, connecting with the truth being spoken by another, and hearing what is spoken by another as her or his truth.

Native American flute music. For those not familiar with Native American flute music, many Indian tribes use the flute in ceremonial rituals and traditional practices as well as a form of entertainment and sharing. Many of the Native American songs played on the flute are love songs or songs played to honor some aspect of nature, sacred animals, and the healing process. Much of the Native American flute music is also very soothing and comforting and sometimes includes gentle chanting to promote balance, harmony, and peace. Native American flute music was likewise incorporated into the talking circle structure as soft background music while the groups were being conducted.²

Group Process

The five talking circle leaders were provided by the program coordinator with talking circle guidelines and instructions³ prior to the beginning of the first talking circles. The coordinator also met with the five group facilitators in a 3-hour training session prior to the beginning of the talking circles to present to them the guidelines and instructions for the talking circles, to answer questions, and to clarify group procedures and logistics.

Each talking circle begins with a process of clearing, in which group members are given time to focus on being in the present, clearing their minds and hearts of thoughts and feelings not related to the immediate concerns of the group. This process begins with the group leader, who holds the talking stick in quietness and silence. The stick is then passed to the group member sitting on the leader’s left (the stick is always passed in a clockwise direction), and that group member likewise holds the stick in the silence and quiet of the group until she or he is grounded in the present. This process is continued, one member passing the stick to the next, until it returns to the group leader.

To further the process of clearing, the talking stick is again passed around the circle to give each member the opportunity to express thoughts or feelings that he or she may be holding, not expressed, from the previous group meeting.
The group leader then asks the group if anyone has anything of immediate concern that they would like to discuss in the talking circle. If someone does have a concern that she or he would like to discuss, this person’s issue or topic is then treated as the group’s immediate secret or burden instead of drawing a secret from the burden basket. On several occasions during the semester, group members presented an issue for discussion in this manner when asked by the group leader.

Other than these situations, the group process involved the leader asking a group member to draw a secret from the burden basket and to read it aloud two or three times. This repetition of the secret likewise focuses group members on the immediate issue and provides them with the time to think and feel about the secret that has been read.

The leader then asks the group a question, something similar to, “If this were your secret, how do you think you would feel?” The group members are instructed that they may use one word only in response to this question, and the stick is passed around the circle from group member to group member as many times as necessary until all group members have had the opportunity to say as many one-word feelings as they desire and no one has anything to add. It is also during this part of the process that a group member may own the secret as hers or his, if this is the case, but only after the talking stick has been passed to that member.

Following this aspect of the process, the leader then asks the group another question, “What part of this secret can you connect with?” or “Let’s see how you connect with this secret.” There are no restrictions on group members’ responses during this phase of passing the talking stick, and it is passed around the circle as many times as needed for all members to express how they connect with the secret. The only time the leader intervenes is if a group member attempts to provide advice. This is done by merely saying to the member, “That’s not a connection; it’s giving advice.” Following the talking stick rule of brevity, the passing of the stick also prevents one or a few group members from dominating the discussion, and it was seldom necessary for any of the group leaders to intervene for this reason.

Typically, one secret drawn from the burden basket will take the entire 1½ hours of the group’s meeting time. If not, however, another secret is drawn from the basket and the process is repeated. The leader may also ask the group members if they have any specific questions they would like to ask of other group members, and they may ask whatever they wish. As in all aspects of the process, any group member may choose to pass or not respond to a question from the group leader or another group member. In other words, group members are not pressured to speak or respond, and their silence and choice to pass is respected.
As mentioned, each talking circle is ended with group members standing in the circle, holding hands, and, beginning with the group leader, saying aloud, “Donelawega,” one at a time in a clockwise direction around the circle.

*Group process examples.* Two examples are provided to further describe the talking circle process. In each case presented, the secret drawn from the burden basket was owned by the group member to whom the secret belonged. The first process description involved the following secret:

My father is an alcoholic and my brother is an alcoholic and drug addict. I am very close to both of them, but I just recently discovered the truth about my dad, and my family wants me to be silent about it and keep it a secret, and it’s tearing me apart inside, and I’m afraid my family will fall apart the more we try to hide it.

After this secret was drawn from the basket by one of the group members and read aloud two or three times, the talking stick was passed around the circle for members’ one-word responses to the leader’s question, “If this were your secret, how do you think you would feel?” When the stick reached the young woman to whom the secret belonged, she said, “That’s my secret,” and she began to cry. She also said that she had found out about her dad over Christmas break, while she was visiting her family on the West Coast, and she returned after break to the University of Connecticut carrying this big secret with her. The leader responded, “Thank you, now we know it’s your secret,” and the stick was passed to the next group member and continued around the circle. Members’ one-word feelings included responses such as, “angry,” “afraid,” “confused,” “sad,” “alone,” “disappointed,” “upset,” “shocked,” and “worried.”

In response to the leader’s question or some variation of it, “What part of this secret can you connect with?” the group members replied with some of the following comments: “My dad’s an alcoholic, too, and no one in my family talks about it.” “Something was going on in my family and everyone knew about it except me, but no one told me about it. When I found out, I felt angry and cheated.” “I can’t imagine what it would be like to be in your situation.” “We don’t have any problems in my family and your secret freaks me out. A problem in my family is when my mom burns the cookies.” “Something was going on in my family, too, and I wasn’t supposed to say anything about it. But I did, and I felt really guilty about saying anything.” “I think every family I know has someone who has a problem with alcohol.” “I can connect to finding out that my dad is very different than I thought he was.”
Group members who own a secret are not asked to provide additional information about the secret. Rather, following the group members’ responses to how they connect with the secret, the group leader returns to the member who acknowledged the secret and asks something like, “What was it like for you to own your secret in the group?” and “What was it like for you to go home and find all this out about your dad?”

The young woman said it was validating for her to hear how other group members felt and how they connected to her secret because what they said was how she was feeling. She also said it was awful for her to return from the West to the East Coast with this huge secret she was not supposed to talk about with anyone outside the family, and they were so far away. As a result of participation in the group she felt accepted, supported, relieved, and no longer alone with her secret.

In the second example, the young woman to whom the drawn secret belonged also owned it as hers: “My neighbor died when I was 15, he was only 16. It was one of the worst parts of my life—no one here at UConn [University of Connecticut] knows this.”

Following the same process as above, group members’ one-word responses included feelings such as “insecure,” “guilty,” “remorseful,” “worried,” “anxious,” “afraid,” “hurt,” “mad,” “unfinished,” and “alone.”

In reply to the group leader’s question, “In what ways can you connect to this secret?” the theme of the group became the losses and deaths encountered by all group members, in some form or manner: “I had a friend who died of cancer and I never dealt with it, I still haven’t dealt with it.” “I had two friends in high school who were killed in a car accident, and I couldn’t bring myself to go to their funerals.” “It’s not the same, but in some ways it is, when my dog died I didn’t know what to do—he was part of the family for thirteen years.” “My grandmother died last spring, and I still haven’t said goodbye to her.”

When the group leader again returned to the group member who had owned the secret and asked how it was for her to acknowledge her secret in the group, the group member said she was still dealing with the death 5 years later and that she was having a difficult time expressing her feelings connected to death. As in the first example, she also said it was helpful to hear that other group members were struggling with feelings related to death and loss and that they, too, avoided their feelings when someone close to them died.

In addition to these examples, group members have also made comments concerning how listening is a “big deal,” how listening slows down everything, and, rather than just reacting to what people say, listening results in taking everyone seriously and respecting them.

Although some group members feel more comfortable talking about some secrets than others do, listening slows down the process and group
members do not pass the stick quickly to the next member. Rather, they hold on to the stick, tap their heads with it, rub it, or just look at it, because they know they have to wait to hold the stick for their turn to speak. This slow pace allows group members to get in touch with their feelings, and it is more difficult for them to intellectualize their feelings; their interactions are quiet and soft spoken—listening and respectful to everyone who speaks.

OUTCOMES

Quantitative Evaluation

Although no validity or reliability data are available, an in-house evaluation form is administered to all HEART Program peer educators-interns at the completion of each academic semester to assess their experience and rate the 13 different program offerings in which they participated during the semester. On a 5-point Likert-type scale (with 5 being the highest and 1 being the lowest rating), the mean rating for the talking circle experience during spring semester 1999 was 4.66 (SD = .97). Because this was the first semester in which the talking circles were offered, no comparative data with other semesters are available. However, in comparison with the other 12 program offerings, the mean rating of the talking circles ranked fourth among all 13 program offering options (overall mean = 4.26, SD = .52).

Qualitative Themes and Verbatim Statements

Perhaps more important to the outcomes of the talking circles for group participants, however, were their unsolicited comments concerning the talking circle experience. The following verbatim statements were written by the talking circle participants in response to a required 15-page internship paper that is completed by all interns at the end of each academic semester. The minimal structure of the required paper asks peer educator-intern students to reflect on and integrate their overall experiences as an intern with the HEART Program in the following four areas: (a) What did you learn about yourself? (b) What did you learn about others? (c) What did you learn about alcohol and drugs? and (d) What did you learn about peer education and counseling?

Although not a formal or pure analysis in the qualitative sense of research, the interns’ papers were read by the authors, and the interns’ unsolicited comments concerning their talking circle experiences were categorized into themes. The authors collaborated in the review of data
to maximize validity (Maxwell, 1996). The comparative analysis (Glaser & Strauss, 1967) yielded three levels of coding (i.e., open, axial, and selective), and the authors double coded all intern papers for reliability (Miles & Huberman, 1994).

The grounded theory that emerged described interns’ experiences of the talking circles in the following nine themes: (a) empathy skills, (b) listening skills, (c) expression of feelings, (d) judgmental stereotypes, (e) connectedness, (f) acceptance or belonging, (g) trust, (h) making a difference or self-efficacy, and (i) peer education. From these themes it appears that talking circles were effective in developing basic helping skills and a sense of community (e.g., empathy skills, listening skills, and positive regard) as well as providing a group experience that promoted self-awareness, personal growth, and self-efficacy (e.g., expression of feelings, connectedness, acceptance or belonging, trust, and making a difference). The following results include only selected examples from intern quotations, but they nonetheless retain the integrity of their reported experiences (Mishler, 1986).

The first four themes (empathy, listening, expression of feelings, and peer education) speak to the psychological sense of community that was built among the interns: developing practical and interpersonal skills that resulted in their relying on one another, dealing honestly with one another on a feeling level, and providing a place for the development of a peer community as an alternative to more formal university counseling services.

**Empathy Skills**

Male: I had never even wanted to empathize with anyone else. I had always thought that other people's problems aren't mine so why should I care . . . but when I started to empathize with a secret I found myself wrapped up in a whole bunch of different emotions. I didn’t care about my original judgments . . . instead, I was interested to see what my peers had to say about their feelings.

**Listening Skills**

Female: [Talking circle] taught me the value of listening to others. I was the type of person who wanted to give good advice to others . . . now I realize how important it is to listen and guide people toward their own decisions rather than telling them what to do about it.

**Expression of Feelings**

Male: I learned that I have a tendency to keep things bottled up inside me until I feel like I've figured them out. I learned that it is extremely impor-
tant to talk to someone. The talking circle provided the opportune time and place to do so. I really appreciated this privilege.

Peer Education

Female: I think that it may have been so helpful because it came from my peers, people who I tend to listen to very closely. I hold what my peers have to say dearly. I think that because they are my peers they understand me a little bit more than a professor or a professional counselor would.

The next four themes to emerge (judgments and stereotypes, connectedness, acceptance and belonging, and trust) reflected the enhancement of group dynamics in the talking circles as well as the interns’ feelings of being accepted; feeling secure, safe, and comfortable; their acceptance of diversity; and the development of trust in the circles. Respect for diversity is a fundamental principle of community (Rucklos Hampton & Norman, 1997; Watts, 1992). The respect and appreciation for diversity (individual and cultural differences) in the talking circles were developed through the interns listening to each other, learning to empathize, and appreciating each other’s strengths and gifts. The interpersonal safety and comfort likewise led to the interns’ ability to accept differences and trust one another (Rucklos Hampton & Norman, 1997). The interns learned to respect the healing aspects of the circles, listening with acceptance and no longer judging and stereotyping others.

Judgmental Stereotypes

Female: I had prejudged others and I learned that many had prejudged me. I saw so many people of a different race, class, and gender and with these differences I placed stereotypes. I was proven dead wrong on these stereotypes during my first talking circle.

Connectedness

Male: I connected very well and learned a lot from the interns in my circle. . . . What was amazing was that we shared a lot of the same experiences . . . even though we came from many different backgrounds and were put in a circle in a random sense, we were still able to relate to one another.

Acceptance/Belonging

Female: I loved the unity that came along with being a member of talking circle . . . we all worked together; we all helped each other.
Female: I never felt that close to a group of people in my life, besides my family . . . all of us felt very secure and comfortable to be there.
Trust

Male: I was never the type of person who could trust people with the secrets and deep feelings that I have inside. I did not feel comfortable speaking about my feelings during the first couple of meetings, but the group soon received my trust and then I was able to speak the truth.

The final theme to emerge related to the interns’ development of competence and self-efficacy in their abilities and skills to help others and discovery that their individual attributes were valued in the community.

Making a Difference or Self-Efficacy

Male: What I learned about myself in talking circle is that by being part of a group and sharing my own personal input, I, too, can help to make a difference.

Two additional categories were also extracted from the interns’ papers in regard to their comments concerning the structure, or process, of the talking circles. These themes are mentioned because they, too, address the interns’ commitment to the talking circles and the importance they placed on empathizing and listening with respect.

Confidentiality

Male: My girlfriend would always ask what my group talked about and I refused to tell her because I knew in my heart that the other group members did not tell anyone what was said.

Burden Basket

Male: The burden basket was the best part of the talking circle because the group was confronted with the random problems of other people. Many of the problems we spoke about were similar to the problems members of the group have experienced . . . by discussing the problems of other people, we learned how to deal with our own problems.

DISCUSSION

The findings and outcomes of talking circles in the context of building a sense of psychological community with undergraduate peer educators-interns who participated in a university alcohol and other drug program are consistent with others who have used peer education to build com-
munity on college and university campuses, most notably King (1994), Manning (1994), and Rucklos Hampton and Norman (1997). With the exception of Rucklos Hampton and Norman, we have found no other attempts to apply talking circles as a specific group structure and process to build community with college students. Even then, Rucklos Hampton and Norman convey only the results of the talking circle as a peer support activity; they do not provide a description of the group structure or the process itself.

In addition to the outcomes we have provided here, however, what we believe to be the most important aspects of the talking circle structure and process are the basic and simple Native American philosophy and rituals of the traditional and ceremonial circle, what most practitioners would likely call “groups.” As indicated by King (1994), the cultural experiences of Native Americans offer many insights for fostering community values on college campuses as well as preparing students to live and work effectively in a multicultural society. We see no need to limit Native American cultural experiences, insights, traditions, and rituals to group work with college students. To us, the traditions and rituals of the talking circle are applicable to any population, group, or context in which the development of a psychological sense of community, multicultural effectiveness, and acceptance and appreciation for diversity are desired.

Part of the traditional and ceremonial circle is seeking harmony and balance in all things: finding balance and harmony in differences and in the universality of commonalties; talking to one another through the expression of honest and true feelings and in the absence of judgments, stereotypes, and fear; and listening with empathy, respect, trust, acceptance and belonging, and connectedness. Talking circles reflect the Native American wisdom of listening and empathy rather than control and interference, self-indulgence, and self-importance; respecting others’ expression of feelings, images, and words through listening and empathy; and honoring, connecting with, and being open to one another. The talking circle interns’ comments reveal this Native American wisdom as well as the Native American purpose of the traditional and sacred circle, Donelawega—building community through the life of the circle (M. Garrett, 1998a, 1998b).

The talking circle celebrates the sacred interrelationship we all share. It symbolizes an entire approach to life. By honoring the circle, we honor the process of life and the process of growth and we honor the healing and transformation that take place in the presence of the group, because we are all related to one another in very basic ways. The circle serves as a very sacred function through the ritual healing and cleansing of body, mind, and spirit. It brings people together to seek harmony
and balance by sharing stories, talking, and sometimes merely sitting
together in silence. The talking circle ensures that relationships are con-
ducted respectfully and serves as a forum for the expression of heartfelt
thoughts and feelings in a context of complete acceptance.

Native Americans believe it is an honor to listen to and talk with oth-
ers, it is a sacred experience to make the connection and open yourself to
others (Nuwati, the energies of others). It is an honor to become the most
that anyone can ever hope to become—a helper. We believe that talking
circles and their application across a wide spectrum of peoples, groups,
and contexts are a path in this direction. It is listening without reacting,
without an intention to respond, without the need to construct
responses or to be witty, intelligent, or critical; it is listening without
being influenced by long-held images or memories or firmly held posi-
tions; it is listening with a beginner’s ear and heart.

Listen, or your tongue will make you deaf.

NOTES

1. A complete description of the HEART Program is available from the primary author.
2. A list of several contemporary compact disks and audiotapes of Native American mu-
sic is available from the primary author.
3. Written guidelines and instructions for talking circle group facilitators are available
from the primary author.

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Anxiety as a Condition for Learning in Group Supervision

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This article describes how group counselors participating in group supervision perceive and experience anxiety. The accounts of these counselors provide perspectives that illuminate anxiety as a condition for learning in group supervision, the group supervisor's role in facilitating learning in group supervision, and the intensity of process-oriented group supervision for supervisees.

Group counselor training is an anxiety-provoking process because of trainees' invariably emerging interpersonal issues (DeLucia, Bowman, & Bowman, 1989; Dies, 1980; Donigian & Malnati, 1997; Duncan & Brown, 1996; Morgan, 1992; Yalom, 1995). Similarly, supervision literature maintains that group supervision features anxiety for essentially the same reasons (Bernard & Goodyear, 1992; Christensen, 1999; Christensen, & Kline, 2000; Holloway & Johnston, 1985; Starling & Baker, 2000; Werstlein & Borders, 1997). Currently, however, the research does not provide an in-depth description of group counselors' perceptions and experiences of anxiety in group supervision.

A recent qualitative investigation explored the experiences of counselors in group supervision (Christensen, 1999; Christensen & Kline, 2000). This investigation discovered that the counselors studied perceived anxiety as an integral and highly significant aspect of their development as group counselors. Although the general findings of this investigation have been reported in the literature (Christensen & Kline, 2000), space limitations precluded discussing group supervisee anxiety in sufficient depth to adequately portray its significance. The goal of this

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article, therefore, is to describe the anxiety that these counselors experienced in group supervision and the perceptions that these counselors had regarding how this anxiety influenced their learning. Counselors’ accounts of their experiences and perceptions with anxiety convey the complexities inherent in training group counselors. These accounts also illuminate the importance of supervising group counselors in groups, the influence of anxiety on how group counselors learn in group supervision, and the developmental qualities of a supervision group.

Experts have contended that anxiety is a common and natural phenomenon experienced by many trainees during counselor supervision and is generally associated with uneasy, worrisome, tense, apprehensive, nervous, or overwhelming feelings (Dodge, 1982; Kline, 1983). Furthermore, research reveals that trainees’ anxiety limits their performance and effectiveness, that effectiveness is inversely related to anxiety, and that counselor anxiety has a cognitive component (Kline, 1983). For the purposes of this article, anxiety is defined idiosyncratically in terms of the perceptions and experiences the counselors studied had in group supervision. Although each of the counselors studied offered different descriptions of their anxiety, the analysis of interview data revealed persistent and highly descriptive themes. In general, each counselor described apprehension over how others would perceive their competence as group counselors and apprehension over potential negative effects that interpersonal feedback might have on their relationships with other supervisees. The anxiety experienced by the counselors studied was conceptualized as participation anxiety (Christensen & Kline, 2000). “Participation anxiety was defined as supervisees’ emotional reactions, thoughts, and behavioral choices regarding how to respond to the anxiety they experienced as participants in group supervision” (p. 382).

**METHOD**

This investigation used grounded theory methodology to explore the experiences of group counselors in group supervision. Participants were involved in three rounds of individual interviews that typically lasted 45 minutes to an hour. Interview data analysis utilized grounded theory coding procedures and analytic tools (Strauss & Corbin, 1998) and several triangulation methods (Denzin, 1978) to ensure the credibility of the findings. To confirm and increase the credibility of the findings further, peer debriefing was conducted using a focus group composed of all participants (Lincoln & Guba, 1985). Peer debriefing confirmed findings
by establishing that the study's findings were consistent with the experiences of the participants.

The participants in this investigation were group counselors enrolled in an advanced group course during the fall semester of 1998 in a northwestern Council for Accreditation of Counseling and Related Educational Programs–accredited counselor education program. These counselors co-led semester-long, process-oriented counseling groups for first semester masters' degree counseling students. Participants attended weekly 3-hour group supervision meetings with a supervising faculty member. For an in-depth description of this methodology, see Christensen and Kline (2000).

**FINDINGS**

Analysis and peer debriefing demonstrated that participant anxiety was the predominant theme and context that framed all of the participants' group supervision experiences. In terms of this study, this meant that participation anxiety was the medium that moderated all of the participants' experiences in their supervision group. Data that pertained to the participants' experience of participation anxiety were organized into five conceptual categories. These categories were affective reactions, conceptual processes, behavioral choices, supervision group development, and the outcomes of coping with anxiety.

Participation anxiety emerged as the group counselors initiated the group supervision process as supervisees. According to supervisees, their participation anxiety was connected with their perceptions of their peers' and supervisors' expectations for their participation in group supervision. Central to participation anxiety were supervisees' fears about appearing incompetent when they showed tapes of their group sessions, offered theoretical explanations of group interaction, or generated group intervention possibilities. Supervisees' fears also were connected to having to share feedback that could harm or potentially destroy their relationships with other supervisees and the supervisor. Supervisees responded to these apprehensions emotionally and cognitively. These responses influenced how they responded to the participation anxiety that resulted from being a participant in the supervision group.

*Affective reactions.* Group supervisees stated that they experienced a range of emotions related to participation anxiety. Supervisees' emotional reactions dimensionalized from fear to ambivalence to excite-
“Group supervision is painful.” “It starts about an hour before supervision begins, I start to feel anxious and excited about what might happen, what I'll learn, and how I'll grow.” These emotional reactions fluctuated throughout the process of group supervision depending on the content and process of the supervision meeting.

In the initial phases of group supervision, supervisees were hesitant to participate because they felt nervous, scared, and angry about the demands of participation. “Initially, I would have definitely characterized anxiety as a hindering and doubtful part of my experience in group supervision.” As supervisees became more familiar with the process of group supervision, their emotional reactions to participation anxiety changed. Some supervisees felt ambivalent about their participation, whereas others felt excited about their experiences in group supervision. Throughout the process of group supervision, supervisees’ emotional reactions to participation anxiety continued to fluctuate between fear, ambivalence, and excitement. Supervisees expressed that they accepted participation anxiety as an uncomfortable, unavoidable, yet motivating aspect of group supervision.

It used to seem to me that anxiety and fear were negative kinds of things. What I’ve realized now is that this is exactly how I learn. Not a perpetual state of anxiety, but if I don’t have some anxiety or fear to motivate me to do something, I wouldn’t grow.

Conceptual processes. Supervisees related their emotional reactions to how they conceptualized participation anxiety. Supervisees conceptualized participation anxiety in terms of their perceptions of evaluation and risk. They believed that their participation anxiety originated from their self-evaluations and perceptions of how other supervisees and the supervisor would evaluate their competence. Supervisees were highly concerned about feeling and appearing adequate, being sufficiently skilled, and being qualified as group leaders and supervision group members. Supervisees were also concerned about their relationships with the group supervisor and other members of the supervision group. Accordingly, supervisees experienced fear and self-doubt regarding their ability and knowledge in group supervision. “Part of the anxiety that I experience is a fear of being judged by myself and others, of not doing it right.” “I will think that I am progressing and taking risks only to go into group supervision and get ripped. My fears get reassured from others and I think, ‘Oh, okay, I really do suck!’”

Supervisees believed that participation anxiety was a part of the risks inherent in group supervision. Supervisees defined these risks in terms of the costs and rewards of participation in group supervision.
Costs of participation included demonstrating incompetence as a group leader, damaging their relationships with other supervisees, and encountering personal issues that interfered with their competence as group leaders. Rewards included learning about theory and skills that improved their effectiveness as group counselors, improving their relationships with other supervisees, and developing insight into personal issues that influenced their abilities as group counselors.

Throughout group supervision, supervisees made decisions about the costs and rewards of participation depending on how they conceptualized the risks and rewards associated with participation anxiety. Some supervisees conceptualized participation anxiety as motivation to participate because they perceived that participation anxiety signaled an opportunity for learning. Supervisees who conceptualized participation anxiety as beneficial focused on the rewards of participation and described how participation anxiety provoked their involvement and growth. “I know that in some ways the anxiety is the spark beneath me that makes me pay attention to what is going on within myself and others.”

Other supervisees conceptualized participation anxiety as a factor that limited their participation. These supervisees focused on the potential costs of participation. Because of their cost focus, participation anxiety stifled their participation and limited the opportunities that these supervisees had for learning. In other words, these supervisees regarded participation anxiety as a signal to withdraw from supervision group interaction. These supervisees described being aware that they chose not to participate in order to manage their participation anxiety and that this choice made their supervision experience less productive. “There is something inherently threatening in the group supervision process. . . . I find myself being anxious and apprehensive about interacting and giving feedback, those are the times when I don’t get much out of group supervision.” “There are times that I see my anxiety as harmful. . . . For me, my anxiety was high, I felt scared and judged, and I interpreted it as a hindering aspect of group supervision.”

**Behavioral choices.** Based on their emotional reactions and conceptualization of the costs and rewards of participation anxiety, supervisees made choices about their involvement in the process of group supervision. When cost-focused supervisees perceived that their participation would be criticized, that they would be seen as incompetent or their feedback would damage a relationship, their anxiety increased. Consequently, cost-focused supervisees would decide to observe and reflect on others’ interactions instead of actively participate. “Sometimes it is just
too risky to say anything, so I don’t. . . . I feel like and do just check out into another world.”

Conversely, reward-focused supervisees felt excited when they experienced participation anxiety because it alerted them to an opportunity for growth. Reward-focused supervisees chose to actively engage themselves in the process of group supervision by giving and receiving feedback, generating possible interventions, and sharing theoretical conceptualizations of group interaction.

It is a lot safer to just sit back and observe/reflect. The real risk is in going for it, engaging and becoming actively involved. . . . Getting into the interactions feels risky, but worth it for me because I grow and learn a lot more when I risk.

Supervisees describe making various choices about their behaviors throughout the process of group supervision. These choices determined the frequency and extent of their interactions with others. Cost-focused supervisees were observed to interact less frequently and be less intimately engaged with others. Conversely, reward-focused supervisees participated actively and more intimately in terms of disclosures about their experiences as supervisees and group counselors and in terms of their interpersonal feedback.

Supervision group development. Supervisees described a continuous process of responding to participation anxiety throughout group supervision. These responses always included emotional reactions to anxiety, conceptualization of participation anxiety in terms of costs and rewards, and choices of behaviors. As the semester progressed, however, this process evolved.

In the initial phases of the supervision group, supervisees feared the evaluations of other supervisees and the group supervisor. To some extent, all supervisees feared that they would be perceived as incompetent, unskilled, and unprepared as group leaders and supervision group members. Consequently, supervisees experienced an uncomfortable level of participation anxiety. Supervisees described perceptions that participation anxiety limited their involvement, personal growth, and learning. During the initial phases of the supervision group, supervisees were tentative about exchanging feedback, asking questions, making requests for input, and sharing reactions. Accordingly, the group supervisor continuously prompted supervisees to participate in group supervision. Despite the supervisor’s efforts, supervisees’ interaction was cautious in the initial phases of group supervision.
“I’ve found myself to be a little hesitant to take part very much because I’m kind of feeling out what my place is in group supervision.” “I’m not sure where I stand in relation with the group at this point.” “At this point in supervision, I don’t trust my peers or myself. I don’t even trust myself to give feedback to my peers.”

As the supervision group evolved, the group supervisor continued to encourage interaction. Over time, feedback between supervision members increased as supervisees’ conceptualization of participation anxiety changed. As supervisees offered and received feedback, they established new and strengthened existing relationships with their peers. Thus, supervisees realized that others were not questioning their competence but were offering reactions and feedback intended to be helpful. As supervisees’ interactions increased in intimacy and frequency, they began to trust others more. As trust developed, supervisees came to believe that their peers and the group supervisor were invested in providing feedback that could facilitate growth. “I have grown to trust my peers and the group supervisor more. Instead of getting anxious and defensive, I have learned to really listen to what others are saying.” “I have learned to trust myself and my peers more.”

Supervisees also described the realization that they were evaluating themselves more frequently than they had in the initial phases of group supervision. They became interested in comparing their self-evaluations with others’ perceptions of them. As they compared their self-evaluations with others’ perceptions, supervisees learned about themselves and the process of group work.

Hell, it is the whole part of group supervision. I know that I am constantly learning something, even if I’m not aware of what it is at that exact moment. . . . There is so much, the interacting between all of us, . . . the feedback, the observations, and the basic relationship skills that I have learned by going through group supervision.

Over time, supervisees became more interested in their relationships with other supervisees and the group supervisor because they respected others’ perceptions and increasingly valued the process of feedback exchange.

I have learned that when I am hammering myself, I’m putting up my own defenses and I’m not as open to feedback from my peers. . . . I was trying to manage all this anxiety and tension that was within me, and my peers weren’t getting in. . . . I realized that I had a choice. I actually stayed open and heard the feedback and got something specific that I can work with. Before, I’m not sure that I had really trusted and opened myself to others in the group. I’ve learned to value my peers and group supervisor.
Supervisees also described the realization that participation anxiety was inherent in group supervision. In particular, supervisees associated participation anxiety with learning, interactions that confronted their fears, and feedback exchange. Consequently, supervisees realized that by facing participation anxiety, by staying involved with their peers and the group supervisor, they experienced the rewards of learning about themselves and the process of group work. Supervisees shared that the more they involved themselves in feedback with other supervision members and the group supervisor, the more their participation anxiety decreased.

I think there came a point for me when it was riskier and more anxiety provoking to not be involved than to be involved. . . . When I am actively involved, no matter what happens, I learn more, trust more, and get more out of this experience . . . what I am saying is that I can’t afford missing out on the rewards that come with the anxiety of throwing my thoughts and feelings out there in group supervision.

As supervisees experienced the benefits of facing participation anxiety, their conceptualization of participation anxiety changed. Supervisees came to believe that participation anxiety alerted them to the possibility for personal and professional growth. Accordingly, supervisees began to see anxiety in group supervision as more rewarding and less costly. Consequently, supervisees felt excited about participation anxiety, perceived the usefulness of their own and others’ perceptions, and believed that participation anxiety prompted their involvement in group supervision. “I have begun to equate anxiety with growth. . . . That has come to me this year in this supervision group. I now interpret anxiety as useful, necessary, and beneficial to my growth.”

In addition to changing their conceptualization of participation anxiety, supervisees also changed their choices of behaviors in the supervision group. The more supervisees conceptualized participation anxiety as a motivating aspect of group supervision, the less tentative their participation became and the less they required prompting by the supervisor. Accordingly, supervisees initiated interactions more frequently, appeared less cautious, and became more spontaneous in their participation. Supervisees also increasingly valued interaction and the feedback they received from other supervisees and the group supervisor. Over time, all supervisees increased the depth and amount of feedback they offered to others, requests for feedback from others, theoretical explanations of group events, and confrontations of others’ behaviors in the supervision group. Essentially, supervisees exercised greater responsibility for their involvement and learning in group supervision and required less direction from the supervisor.
Outcomes of coping with anxiety. Supervisees' responses to participation anxiety influenced their choices about participation in group supervision. Thus, participation anxiety influenced what and how supervisees learned. When supervisees were actively involved in the supervision group, they increased their self-awareness, understanding of their interactions with others, and confronted relationship issues. As supervisees learned more, they learned more about the importance of feedback and how their unique styles of interacting with others had an impact on the groups they led. Thus, by interacting with others and working through relationship issues within the context of group supervision, supervisees learned how to facilitate group process. Group supervisees described enhanced self-awareness, improved communication skills, and believed that they developed their effectiveness as group counselors because of their interactions with others in the supervision group. This learning required each supervisee to confront and manage participation anxiety. “I know that my anxiety, the way that I handle it, and my emotional reactions actually enhanced my learning.” “I would have never believed how beneficial it would be for me to learn how to handle and experience anxiety in group supervision. Especially as it related to my relationship issues of trusting my peers enough to share, interact, and offer critical feedback, despite my fears.”

DISCUSSION

The purpose of this article was twofold: (a) to describe the anxiety counselors experienced in group supervision and the perceptions these counselors had regarding the influence of this anxiety on their learning and (b) to explore the implications of anxiety on counselor education and supervision.

The descriptions of anxiety in this article were the most significant findings of a larger study (Christensen, 1999) in which group counselors described participation anxiety as the dominant aspect of their group supervision experience. In this study, supervisees consistently referred to participation anxiety as they described what they experienced, how they learned, and what they learned throughout group supervision.

During the time supervisees participated in group supervision, they gradually changed their perceptions of participation anxiety. At first, supervisees interpreted participation anxiety as an indication to limit their depth of involvement. As trust developed and they began to experience and observe learning in the supervision group, supervisees began to change the meaning they assigned to the emotions and thoughts they experienced in relation to participation anxiety. At this point, super-
visees seemed to master the interactive learning process inherent in group supervision and they began to believe that participation anxiety signaled a valuable learning opportunity.

Based on the anxiety they experienced and the intense interactions that supervisees had with one another in group supervision, supervisees began to realize that their insight regarding relationships with their coleaders and significant others had been enhanced, that their understanding and development of group facilitation skills had increased, and that they had experienced an overall improvement in their interpersonal interactions. In addition, the group counselors/supervisees studied shared that they learned for themselves the importance of self-awareness and anxiety as a condition for learning and growth as group counselors.

The accounts of group counselors in group supervision aid in the understanding of supervisees’ affective, conceptual, and behavioral experiences in group supervision. By defining participation anxiety as an integral aspect of learning in group supervision, this discussion provides several perspectives on the effects of anxiety and how learning occurs in group supervision for group counselors. This perspective describes participation anxiety as a condition for learning and the developmental processes that exist in supervision groups with group counselors.

By being aware of the effects of anxiety on learning, counselor educators and supervisors will be better prepared to assist supervisees as they learn to accept and understand anxiety. As Donigian and Malnati (1997) suggested, “Group therapists need to learn to feel comfortable with anxiety, for if they run from it or choose not to turn toward it, they will miss the opportunity to use this primary force of change” (p. 12).

In addition, supervisors and counselor educators can actively address and facilitate the expression of participation anxiety by supervisees. Supervisors can also learn to effectively utilize the group supervision format to teach supervisees effective coping strategies for anxiety. This suggestion is consistent with those made by Kline, Falbaum, Pope, Hargraves, and Hundley (1997). “The group process, after initial anxiety, can help students develop comfort and skill in giving and receiving feedback” (p. 165).

The authors hope that this initial description of group supervisees’ participation anxiety will aid group supervisors as they endeavor to understand the experiences of their supervisees. The accounts of supervisees’ participation anxiety should also assist group supervisors in developing new or modifying existing strategies to assist supervisees as they learn to confront and even appreciate participation anxiety in group supervision.
For example, Dodge (1982) provided a cognitive-behavioral approach for reducing supervisee anxiety in individual supervision. This model suggested that supervisors guide supervisees in the following process: (a) acknowledging and accepting their anxious feelings and defensive reactions, (b) identifying their underlying irrational beliefs, persistent disputes, and arguments against these beliefs, (c) constructing more rational ways of thinking, and (d) taking behavioral risks. Kline (1983) proposed a self-instruction model that included teaching counselor trainees to talk to themselves in order to focus their attention on client issues and away from anxiety. Although both of these models were designed for use in individual supervision, information presented in this article may assist supervisees in understanding and modifying such models to fit the unique needs of group counselors in terms of how they manage and utilize their anxiety as a condition for learning in group supervision.

This discussion indicates that supervisors who want to utilize interpersonal learning processes in their supervision groups must understand the developmental qualities of their supervision groups. That is, the fears that group members have in newly forming groups are the same fears that group supervisees experience when their supervision group first convenes. Thus, the interventions and continued encouragement a group leader would provide to help members discuss their apprehensions should be incorporated into the initial developmental phases of a supervision group. Clearly, group supervisors should attend to supervisees' apprehensions because these apprehensions dictate what and how supervisees learn.

Finally, because this investigation was qualitative, there are a number of important implications for counselor educators and supervisors interested in using group supervision to train group counselors. The most crucial implication is that educators and supervisors begin conversations about supervisees' participation anxiety in group supervision and discussions of how participation anxiety influences what and how supervisees learn. The authors hope that these conversations will lead to utilizing the full potential of group supervision as a powerful learning tool for group counselors.

REFERENCES


Pretherapy Training of Therapeutic Factors for Members of Counseling Groups

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This study investigated the effectiveness of a training video on group process and outcomes. The video taught four therapeutic factors: cohesion, catharsis, universality, and instillation of hope. Participants were 91 students who participated in 12 groups. A repeated measure, two-group design was employed. Members’ perceptions of the frequency of the therapeutic factors, the leaders’ effectiveness, and members’ problem alleviation were measured. The video showed a strong training effect and positively affected the members’ perceptions of the leaders’ effectiveness. No significant differences were found for frequency of therapeutic factors or problem alleviation between groups.

New members often struggle to learn how to function effectively in a group. Pretherapy training has been shown to be an effective way of enhancing members’ experiences and outcomes in group therapy (Piper, Debbane, Bienvenu, & Garant, 1982; Rabin, 1970).

Yalom, Houts, Newell, and Rand (1967) theorized that pretherapy training is effective because it gives members structure that helps form a more freely interacting group. Piper, Debbane, Garant, and Bienvenue (1979) claimed that pretraining provides a safe situation that increases the positive bonds between members. Yalom (1985) asserted that such training creates a therapeutic alliance between the leaders and members.

Logically, the content of any training should be based on elements that are most effective in facilitating group processes and helping members improve, that is, therapeutic factors (Bloch & Crouch, 1985; Butler & Fuhriman, 1983; Yalom, 1985). By teaching such factors at the beginning of a group, leaders give members the tools that will enable them to
have a more productive group experience. Because therapeutic factors are interrelated (Yalom, 1985), focusing on a few important factors should increase the use of all factors.

The pretherapy training in this study included four therapeutic factors to typify the important processes of group: cohesion, catharsis, universality, and instillation of hope. The factors were representative of Waldo’s (1985) framework including relation to group concerns, developmental stages, theoretical perspectives of leaders, and leader behaviors. Butler and Fuhriman (1983) summarized findings in which members rated factors according to their importance and found catharsis, cohesion, and universality rated consistently in the top four. Instillation of hope was considered crucial as a condition for change to group therapy by Yalom (1985).

Video has been shown as an effective and convenient format for pretraining group members (Cartwright, 1976; Curran, 1978). Bowman and DeLucia (1993) showed that pretraining can be effective even when the content is presented by someone other than the leader. It is the hypothesis of this study that members receiving the pretherapy training will show a significant increase in perceptions of all therapeutic factors, will show greater respect for their leader’s abilities, and experience greater problem alleviation.

**METHOD**

**Participants**

Participants were 91 students from a medium-sized public university in northern California who registered for one of several psychology small-group-experience classes (80% women and 20% men). The average age was 22 years. Participation was voluntary and credit was based solely on attendance. No members declined to participate. The majority of members had little or no previous group experience.

**Leaders**

Six trainee leaders, (five women, one man) led two groups each. The average age was 35 years. Leading these groups was part of a practicum required for a master’s degree in psychology, and supervision was provided by Ph.D.-level instructors with professional qualifications in training leaders.
Assignment to Groups and Treatment Conditions

Twelve groups were studied. All of the groups followed a generic personal-growth and problem-solving format \( (N = 91) \); five \( (n = 42) \) were also thematic (e.g., women’s issues). Participants registered for particular groups and were not randomly assigned to specific groups. The group sessions were 2 hours long and lasted approximately 14 weeks, meeting once per week. All leaders led two groups and were assigned one group from each treatment condition. The groups had a mean membership of 7 and a median and mode of 6. Experimental groups contained 40 members with a mean of 6.7 and a median of 6.5. Control groups contained 51 members with a mean and median of 8.5. Differences between the number of members were not significant according to a chi-square analysis, \( \chi^2(1, N = 91) = 1.330, p < .30 \).

Treatment Conditions

Videos were presented during the second session of the group. Initial sessions were reserved for the development of norms and member and leader bonding. Leaders left during the videos to keep them blind from the videos’ contents, and members were asked not to reveal the contents to the leaders. The entire presentation, including pretesting, lasted about 35 minutes.

Experimental. The video shown to the experimental groups presented the four therapeutic factors in the following format: (a) a brief verbal definition and explanation, then (b) a scripted, role-modeled example provided by nonprofessionals portraying a generic, growth-oriented group. The video was 25 minutes in length.

Control. The control video depicted the first author discussing interpersonal factors that were not part of the experimental group’s video (e.g., relaxation, self-awareness). This video was also 25 minutes in length.

Measures

Construct validity of the experimental condition. A pretest and posttest questionnaire was developed to test for the training effect of the video. There were eight multiple-choice questions, two questions per therapeutic factor. To enhance content validity, the questions were
based on Yalom’s (1985) definition of the factors. The tests asked mem-
bers to match written vignettes with the corresponding therapeutic fac-
tors. The tests were administered before and after the video. A total
score was obtained for each individual.
Cronbach alphas for the video pretest and posttest were .54 and .48,
respectively. Because the test consisted of only eight items, an equal
length Spearman-Brown split half was calculated, $r = .80$ and .94,
respectively ($n = 77$).

**Therapeutic Factor Questionnaire (TFQ).** The TFQ was used to assess
group members’ perceptions of the factors (Schultz, 1990). Members
completed this questionnaire at the end of the last group. An abbrevi-
ated version of Yalom’s (1985) 60-item scale, the TFQ is a 20-item instru-
ment with 2 items per factor instead of 5. Ten of Yalom’s original 12 were
selected for use: instillation of hope, universality, imparting of informa-
tion, development of socializing techniques, imitative behavior, inter-
personal learning, intrapersonal learning, group cohesiveness, cathar-
sis, and existential factors. Altruism and family reenactment were left
out because both were decidedly less significant for the types of groups
being studied. This measure has been used at the university for several
years and has been shown to be reliable, with alpha coefficients of .45,
.31, .51, .60, .69, .75, .51, .85, .49, and .43, respectively (B’nah, 1993;
Schultz, 1990). The TFQ tested members’ perceptions of the rate that
these factors occurred, on a Likert-type scale from 1 (not at all) to 5 (al-
ways). Scores were tabulated by adding members’ ratings into one total
score.

The Cronbach alpha was calculated at .86 (Noruisis, 1990).

**Leadership Evaluation Questionnaire (LEQ).** The LEQ was used to
assess members’ perceptions of their leader’s effectiveness at the end of
the group. The LEQ is a 44-item instrument developed by Schultz (1990)
and later refined by B’nah (1993), based on the works of Lieberman,
Yalom, and Miles (1973). The total scale is divided into four sub-
scales that measure a leader’s effectiveness in utilizing four basic skills:
(a) empathy/caring, (b) meaning attribution, (c) emotional stimulation,
and (d) leading/executive function.

The LEQ asked members to rate what amount of time those state-
ments on the questionnaire were true about the leader. Statements were
rated on a Likert-type scale of 1 (0%) to 5 (100%). There were 11 ques-
tions for each of the four subscales. Scores were calculated for the total
scale and each subscale.

Cronbach alphas for the LEQ were as follows: total scale = .95; Car-
ing, Meaning, Emotions, and Leading subscales = .83, .87, .81, and .82,
respectively, for this sample. B’nah (1993) and Banaka (1993, N = 406) previously calculated the Cronbach alphas and split-half reliabilities for the LEQ with similar results (split halves in parentheses): total scale, .95 (.96); Empathy, .87 (.88); Meaning, .86 (.91); Emotions, .85 (.86); and Leading, .77 (.82); thus, the internal consistency of the LEQ appears high.

Problem alleviation. The Problem Inventory (PI) was developed by the authors to assess members’ levels of self-perceived problems, covering the areas that concern college students. Twenty-six items were chosen to represent social, psychological, academic, and physical problems such as friendships, managing stress, school adjustment, depression, health, and so forth. The PI asked members to rate each potential problem on a Likert-type scale from 1 (absent) to 7 (severe). A total score for each member was tabulated. The PI was administered during the second group session and after the last group session.

The Cronbach alphas for the PI pretest and posttest were .83 and .91, respectively, promising reliability for a new measure.

RESULTS

Preliminary Analyses

Construct validity of the experimental condition. A repeated measures ANOVA with the treatment as the independent variable and time as the repeated measure and pretest/posttest video questionnaire as the dependent variable was employed. The experimental manipulation reflected a main effect for time (within participants) and treatment (between participants) that was significant and demonstrated good construct validity of the treatment, \( F(64, 40) = 138.51 \) and \( 731.14 \), respectively, \( p < .001 \). Forty experimental group members pretested and posttested; the means were 2.8 \( (SD = 1.7) \), and 5.1 \( (SD = 1.1) \), respectively. The training video was effective in training members concerning the four therapeutic factors.

Main Hypotheses

Members’ experience of therapeutic factors. A MANOVA was calculated between conditions wherein viewing the video was the independent variable and the score on the TFQ subscales was the dependent variable. There was no statistical significance found for the entire scale, \( F(1, \)
The experimental group \((n = 40)\) had a mean of 71.15 and a standard deviation of 11.46. The control group \((n = 34)\) had a mean of 69.26 and a standard deviation of 10.46. The main effect for measures was significant, \(F(1, 9) = 10.373, p < .001\). When comparing the means of each subscale, only one was significantly different, Interpersonal Learning, \(F(1, 72) = 8.141, p < .006\). Smith (1993) analyzed data from all of Yalom’s (1985) questionnaire items for the four therapeutic factors shown in the video but found no significant difference using a one-way \(t\) test between the means \((p < .251)\). The hypothesis was not supported.

**Perceptions of leadership qualities.** A one-way \(t\) test was calculated between the average scores from the experimental and control groups wherein the viewing of the video was the independent variable and the rating on the LEQ was the dependent variable. A significant difference was found for the total scale and each subscale \((p < .001)\), thus supporting the hypothesis. Table 1 shows the number, mean, standard deviation, \(t\), degrees of freedom, and effect sizes for the LEQ.

**Members’ level of problem alleviation.** A repeated measures ANOVA was calculated on an average score for the PI between the treatment conditions wherein the independent variable was the video and the de-
dependent variable was the members’ ratings on the PI. The experimental group had a pretest mean of 66.87 (SD = 16.16) and a posttest mean of 57.03 (SD = 16.69). The control group had a pretest mean of 55.77 (SD = 13.95) and a posttest mean of 49.74 (SD = 12.53). Even though both experimental and control groups reported significant levels of problem alleviation (within participants) on the PI, the interactive effects were not significant, $F(1, 64) = 1.08, p < .302$.

**DISCUSSION**

There were no significant differences as to the members’ use of therapeutic factors or in their report of problem alleviation. However, the results did show a significant, strong relationship between members’ viewing the training video and a more positive evaluation of their respective leaders. The video format provided a standardized way to efficiently train members and showed a strong training effect.

For both control and experimental groups, there was one significant outcome for the TFQ—the Interpersonal Learning subscale. On average, all participants experienced that factor the most, showing that it was prominent.

There are a few possible reasons that early exposure did not increase members’ use of therapeutic factors or ratings of problem alleviation. First, the control video taught some intrapersonal factors (e.g., self-disclosure), which could have had some training effects on members, calling for a more neutral presentation in further studies. Second, more experienced group leaders may have been more likely to enhance member interactions, resulting in greater levels of therapeutic factors and problem alleviation. Finally, treatment effects of a training video could fade by the end of the semester, leading to no significant differences between the groups on their ratings of therapeutic factors or problem alleviation.

It appears that members in the experimental groups were able to better understand and appreciate the behaviors of group leaders. Yalom (1985) said that pretherapy training decreases the initial extrinsic anxieties and false expectations often unproductive to groups. This reduction of distracting processes in members may have increased understanding and provided for better response to the leaders’ behaviors. Another possibility is that the video modeled appropriate member-to-leader interaction, thus clarifying roles and providing a positive initial view of the leader.

A flaw in the design occurred when the experimental groups rated their problems on the PI after they viewed the video, which may have sensitized the members to be more focused on personal problems at pre-
testing. This could account for their higher scores on the pretests and the higher variability of scores.

A limitation in the treatment of the control group occurred when the group received no video pretest or posttest, therefore not isolating the extent to which the mere repetition of the tests resulted in a practice effect. Other limitations of the study were that all measures were self-reports and that college students do not typically seek treatment per se.

A strength of this study is that groups were compared in which leaders were randomly assigned both control and experimental conditions. This allowed control for any effects due to differences in leadership styles. An estimate of not controlling for such variables obtained by Smith (1993), who analyzed data including ten additional groups in which leadership style was not controlled, show findings were weakened for the LEQ.

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Principal Components Analysis of Important Goals for Group Work With Male Inmates

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The purpose of this study was to identify important goals for group work with male inmates from the perspective of 162 group therapy providers and mental health program directors. A principal components analysis with an oblimin rotation resulted in eight goal factors for group work with adult male inmates accounting for 70% of the common variance. These factors included self-exploration and learning within a supportive group environment, group relationship building, substance abuse, learning healthier attitudes and behaviors, conformity, prosocial behavior, lifestyle, and institutional adjustment. Implications for group practice and research with male inmates are highlighted.

Group counseling and psychotherapy services have been an important component of rehabilitation for inmates in correctional settings; however, it is still a relatively new area of research. Of interest, little is known about therapists’ perceptions of important goals for group work with inmates. It has been argued that “specific, well-defined and realistic” goals should be developed to guide group work with inmates (Rizvi, Hyland, & Blackstock, 1983), and these goals need to be “achieved and
evaluated fairly quickly" (Bonta, Cormier, Peters, Gendreau, & Marquis, 1983, p. 137).

However, little has been written specifically to address the overarching goals for group programs with inmates. Several general goals have been alluded to in the corrections literature. For example, participation in groups may help inmates learn more about themselves (Kahnweiler, 1978) and their values and opinions (Scott, 1993). Groups may also assist inmates in improving their relationships with others (e.g., members in the group, family members, friends, inmates, and prison staff) (Gendreau, 1996; Ionedes, 1962; Kahnweiler, 1978) by teaching effective communication skills and altruistic behaviors (Kahnweiler, 1978) as well as emphasizing the importance of relationships. General group dynamics as well as specific topics of discussion can serve as synergists for self-understanding and empathy for others. It is also important to help inmate clients find the motivation to learn (Ionedes, 1962; Scott, 1993) in general, not only about themselves and others, but also to make important changes in their lives. A general goal that is clearly related to rehabilitation is modifying delinquent behavior (Wardrop, 1976). Group work may provide inmates with the opportunity to learn that there are other ways of achieving their goals in life without breaking the rules or harming themselves or others. Addressing and working through substance abuse issues can oftentimes be an important goal in group work with inmates (Gendreau, 1996) given the fact that approximately 21% of inmates in state facilities and 60% of inmates in federal penitentiaries are incarcerated for drug-related offenses (Haney & Zimbardo, 1998).

Related to substance abuse and addictions, inmates can also learn about their addictive behaviors in general, as some inmates may be addicted to a criminal lifestyle (Walters, 1990). Group goals can also be established to help inmates deal with lifestyle concerns related to career development and leisure interests (Gendreau, 1996), which may provide a sense of mission or purpose in life. Process goals for group work with inmates may also include providing support (French, 1981), developing new and meaningful learning experiences (Stasiw, 1977), and learning to express anger and affection (Halleck, 1967) in appropriate ways.

It is also possible that group therapists in correctional settings might identify Yalom's (1995) therapeutic factors (e.g., instillation of hope, universality, existential factors, and the corrective recapitulation of the primary family group) as important content and/or process goals with inmates. Five previous studies have explored therapeutic factors in correctional groups with male inmates (Long & Cope, 1980; MacDevitt & Sanislow, 1987; Morgan, Ferrell, & Winterowd, 1999; Steinfeld & Mabli, 1974). However, they were not investigated within the context of under-
standing the overarching group goals with inmates as perceived by group therapists.

Unfortunately, group goals are not often clearly delineated in research studies on group work with inmates (Slaikeu, 1973). More research is needed to understand what group therapists value as important group goals with male inmates. These group goals will ultimately influence the focus and direction of group work, particularly of content and process issues. To date no research has focused on therapists’ perceptions of important content and process goals for group work with inmates. In this study, a principal components analysis was conducted to identify key factors associated with the important process and content goals for group work with male inmates from the group therapists’ perspective.

**METHOD**

**Participants**

Participants consisted of 162 group therapy providers and mental health program directors from 79 randomly selected state penitentiaries and correctional facilities for male inmates in the United States. Of the 50 states, 48 were represented by at least one participating correctional facility. The participants included 100 men and 60 women (2 participants did not indicate their gender), with a mean age of 44.8 years ($SD = 10.14$). They were predominantly Caucasian ($n = 139$); however, other ethnic groups represented in this sample included African American ($n = 11$), biracial ($n = 3$), Hispanic/Latino/Latina ($n = 1$), Native American ($n = 2$), Asian American ($n = 1$), and other ($n = 1$). The majority of the participants were group therapy providers ($n = 118, 72\%$), whereas 38 participants were directors of psychological or mental health departments ($24\%$). Of the 38 participants who identified themselves as program directors, more than $90\%$ reported facilitating group work within the past year. The average years of group work experience was 6.5 years ($SD = 6.05$). One hundred and twenty-three of the 162 participants had obtained a doctoral or a master’s degree. The majority of these professionals were from the specialty areas of clinical psychology ($n = 48$), counseling psychology ($n = 31$), social work ($n = 31$), or counseling ($n = 27$). Cognitive-behavioral ($n = 51, 31.5\%$) and eclecticism ($n = 50, 30.9\%$) were identified as the most common counseling theoretical orientations. Finally, the respondents were employed in state correctional facilities ranging in inmate population from 46 to 20,000 (most likely a prison complex), with a median of 1,162.5 and a mode of 900 inmates.
Survey

A five-page survey was developed by the authors to assess a wide range of areas related to group programs in correctional facilities. One section of this survey asked the participants to respond to questions about potential group goals, discussion topics, and areas of related progress. The researchers developed a list of 33 content and process issues for male inmate groups. These items were developed based on (a) research findings and theoretical formulations in the corrections literature related to group work with male inmates, (b) group theory (e.g., Yalom, 1995), as well as (c) research team members’ professional experiences in facilitating psychotherapy groups with male inmates. The 33 items included content as well as process components of group work with male inmates. It should be noted that Yalom’s (1995) 11 therapeutic factors were included in this list. For the purposes of this study, only the results of the group goals section of this survey were factor analyzed and discussed.

The list of the 33 group goal items included (1) self-esteem enhancement, (2) catharsis (venting feelings), (3) exploring and working through early childhood events/traumas, (4) having hope/faith in group treatment, (5) improving relationships with partners and family members, (6) assertiveness training, (7) group members recognizing similarities in each others’ problems, (8) group members offering advice and suggestions to one other, (9) the importance of relationships within the group, (10) group members learning to help others, (11) normalizing group members’ problems, (12) group cohesion, (13) working through substance abuse and/or dependency problems, (14) reducing addictive behaviors/relapse prevention, (15) imitating new behaviors, (16) stress management, (17) developing more realistic thoughts, (18) insight/personal growth, (19) impulse/anger control, (20) mood adjustment, (21) conflict resolution, (22) strategies to avoid reoffense cycle, (23) complying with institution rules and regulations, (24) preparing inmates for life outside of prison, (25) teaching social skills, (26) teaching career planning, (27) diet/nutrition and exercise, (28) developing leisure activities, (29) improving relationships with prison staff, (30) institutional adjustment, (31) improving relationships with inmates, (32) existential issues (e.g., coping with loss of freedom), and (33) crisis intervention.

Using a 7-point Likert-type scale ranging from 1 (not at all important) to 7 (very important), participants were asked to respond to the following question for each of the 33 content and process items: In considering the overall goals of your groups, how important are the following as group goals?
A cover letter explaining the purpose of this study and postage-paid, self-addressed envelopes were provided with each survey.

Procedure

For this study, 113 state penitentiaries (correctional facilities) were randomly selected from the 1994 American Correctional Association’s directory that includes listings of 700 adult male institutions. The director of the mental health department at each site was called by one of the researchers to explain the nature and purpose of the study and to assess their interest in participating in the study. If the director verbally committed to participate in this study, he or she was asked for the number of surveys needed (i.e., one for themselves and one for each group therapy provider). Copies of the cover letter and survey were then mailed to the department. If the survey was not returned within 2 weeks of the date the survey was mailed, a postcard encouraging the return of the surveys was mailed to the director.

Of the 113 facilities randomly selected, 79 facilities agreed to participate in this study. Three hundred and eighty-six surveys were sent to these 79 facilities based on the number of mental health professionals who provided group work to male inmates at these sites. All 79 facilities returned at least one survey. One hundred and sixty-two surveys were completed and returned (return rate of 42%).

Thirty-four state correctional facilities did not participate in this study for a variety of reasons. Twenty-five facilities did not offer group psychotherapy services. Six facilities could not be reached by phone. One facility was in the process of closing. One facility required a lengthy proposal review process and therefore the researchers of this study did not pursue data collection with this site. Only one facility declined to participate in this study.

RESULTS

A principal components analysis with an oblimin rotation was conducted on the 33 items that the group facilitators rated for importance as group goals. The oblimin rotation was selected given the authors’ theoretical rationale that goals in group counseling and psychotherapy ought to be related to one another. In addition, an examination of the intercorrelations among the factors following extraction confirmed the use of the oblimin rotation.

Based on the Kaiser rule (retain factors with eigenvalues greater than 1) and an examination of a scree plot, eight components were ex-
tracted from the structure matrix. These eight factors accounted for 70% of the common variance and each represented a theoretically meaning-
ful structure. For the purposes of this study, loadings used in the interpre-
tation were determined by “testing each loading for significance at alpha = .01 (two-tailed test)” as suggested by Stevens (1996, p. 371). An absolute value of .434 was utilized in this study, so that all loadings equal to or greater than this absolute value were used for interpreting
the factors. Twenty items loaded on more than one factor at or above the .434 criterion and were included in all of those factors. See Table 1 for
the structure matrix for these goal factors.

Factor 1 (Self-Exploration and Learning Within a Supportive Group Environment) had an eigenvalue of 11.88 and accounted for 36% of the common variance. Fifteen items loaded above our absolute value (.434), and these items related to the importance of group members learning about oneself through the expression of in-depth issues and learning relational and coping skills within a cohesive and supportive group environment.

Factor 2 (Group Relationship Building) consisted of eight items with loadings greater than .434. The eigenvalue for Factor 2 was 2.52 and accounted for 7.6% of the common variance. The nine items retained for this factor focused on the development of interpersonal relationships in group as well as group relationship dynamics.

Factor 3 (Substance Abuse) had an eigenvalue of 2.19 and accounted for 6.6% of the common variance. Two items loaded on this factor. These items inquired about the importance of focusing on substance abuse issues as well as the importance of reducing addictive behaviors.

Factor 4 (Learning Healthier Attitudes and Behaviors) had an eigenvalue of 1.76 and accounted for 5.3% of the common variance. Eleven items loaded on this factor and consisted of the acquisition of behavioral skills (e.g., social skills training, conflict resolution, impulse/anger control) and insight (e.g., personal growth, self-esteem enhancement).

Factor 5 (Conformity) had an eigenvalue of 1.47 and accounted for 4.5% of the common variance. This factor consisted of four items addressing recidivism issues and institutional compliance.

Factor 6 (Prosocial Behavior) had an eigenvalue of 1.12 and accounted for 3.4% of the common variance. The six items that loaded on this factor focused on improving relationships and preparing for life outside of prison.

Factor 7 (Lifestyle) had an eigenvalue of 1.08 and accounted for 3.3% of the common variance. This factor consisted of eight items that addressed career issues, diet, stress management, and the development of leisure activities.
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<td>Assertiveness training</td>
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<td>Group members offering advice and suggestions to one other</td>
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<tr>
<td>The importance of relationships within the group</td>
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<td>Group members learn to help others</td>
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NOTE: Significant loadings of .434 or higher are in bold print. Factor 1 = Self-Exploration and Learning Within a Supportive Group Environment; Factor 2 = Group Relationship Building; Factor 3 = Substance Abuse; Factor 4 = Learning Healthier Attitudes and Behaviors; Factor 5 = Conformity; Factor 6 = Prosocial Behavior; Factor 7 = Lifestyle; Factor 8 = Institutional Adjustment.
Factor 8 (Institutional Adjustment) had an eigenvalue of 1.06 and accounted for 3.2% of the common variance. This factor consisted of 11 items that focused on inmates' need for dealing with prison life including improving relationships with prison staff and inmates; managing stress, anger, and crises; and dealing with existential issues of imprisonment.

**DISCUSSION**

The purpose of this study was to identify key factors associated with the important process and content goals for group work with male inmates. Eight factors emerged, which accounted for 70% of the common variance: Self-Exploration and Learning Within a Supportive Group Environment, Group Relationship Building, Substance Abuse, Learning Healthier Attitudes and Behaviors, Conformity, Prosocial Behavior, Lifestyle, and Institutional Adjustment. The findings of this study will be discussed with regard to the types of training group therapists need to achieve the skills and competence to work with male inmates.

Counselors and therapists who provide group services to male inmates in correctional facilities tend to value some of the overarching goals that hold true for many counseling and psychotherapy groups in general, including clients' self-exploration and learning; the development of healthier attitudes and behaviors, including lifestyle issues; and relationship building within the group environment. Therefore, the general training counselors and therapists receive in developing and fostering growth within a supportive group environment is very important to the facilitation of group work with male inmates.

Counseling and psychotherapy provide opportunities for inmates to gain self-understanding (Hardy & Cull, 1974; Kahnweiler, 1978) and self-expression (Kahnweiler, 1978; Scott, 1993) compared to the milieu of the correctional institutions at large. Oftentimes, groups provide an outlet for inmates to talk out their thoughts and feelings about their past criminal activity as well as their relationships with others including family, friends, fellow inmates, and prison staff. For inmates, group may be their place to learn how to share or release pent-up thoughts and feelings in socially and therapeutically appropriate ways without hurting themselves or others in the process.

Learning healthier attitudes and behaviors has been considered an important process in group work with inmates (Scott, 1993) and was a significant group goal factor regardless of the theoretical framework of the therapists in this study. Groups not only provide inmates with the
opportunity to learn new ways of thinking, feeling, and behaving, they also help inmates learn more about their relationships in the here and now (Gendreau, 1996; Ionedes, 1962); inmates may be able to relate better to others by realizing the common experiences shared, the value and importance of relationships, how they can help one another, and how they personally affect group members and the group therapist (Group Relationship Building).

Improving inmates’ general lifestyle, including career development, diet, leisure, and stress/life management, may help facilitate inmates’ eventual return to society. A successful integration into society certainly must include gainful employment. Unfortunately, few inmates have the necessary skills to identify, pursue, and/or obtain meaningful employment. As such, many offenders resort to previous patterns (i.e., criminal behavior) for earning a living, by default. Along similar lines, in the absence of substance abuse and criminal behavior, inmates are often left without a means of entertainment. Thus, the focus on the development of a healthier lifestyle appears essential to the rehabilitation process.

According to the “Professional Standards for the Training of Group Workers” (Association for Specialists in Group Work, 2000), overarching goals guide group interventions. In addition, different types of group goals and interventions are required for different types of group work, with implications for training. There are some unique, overarching goals related specifically to group work with male inmates that require additional training on the part of counselors and therapists to address the specific needs of these inmates. These goals include substance abuse and addictive behavior recovery, prosocial behavior modification, conformity issues, and institutional adjustment. By learning to work through substance abuse and/or dependency problems, male inmates may be able to see the relationship between their alcohol and/or drug use and their engagement in past criminal activities. Focusing group work on issues of prosocial behavior and conformity appears essential to help decrease recidivism. Inmates can learn how to relate more positively and meaningfully with others by learning prosocial skills (Bonta et al., 1983; Gendreau, 1996). Groups teach inmates that there are social and conventional rules in every context. By learning the consequences of their actions on others and learning how to resolve conflicts in group, they can transfer this knowledge into their daily life.

Institutional adjustment has been an important component of correctional group work (e.g., Slaikeu, 1973; Sultan & Long, 1988; Zimpfer, 1992). Institutional adjustment focuses on helping inmates cope with and adjust to their incarceration. Part of the adjustment process involves the discovery of meaning and coping with losses of freedom as part of one’s existence in the prison setting. However, better institu-
tional adjustment in a correctional facility has been related to poor postrelease adjustment (e.g., Homant, 1986). It is possible that the more inmates adjust to the prison environment the more difficulty they have reintegrating into society.

The factors identified in this study provide a meaningful conceptual framework from which to understand the overarching group goals with male inmates according to a national survey of group therapists in state correctional settings. In terms of group interventions with male inmates, counselors and therapists will need to balance basic group goals such as personal growth and group relationships with the specific needs of male inmates including substance abuse recovery, prosocial behavior, and conformity, as well as adjustment to prison life itself. Additional training may be necessary in these specialty areas. In addition, further training is recommended in the use of confrontation skills as well as in managing security and safety issues when conducting groups in correctional settings. Counselors and therapists must feel safe in challenging male inmates to grow without the fear of retaliation, including physical injury or psychological manipulation.

This is the first study to identify content and process group goal factors across group programs with male inmates. Although researchers in the field have alluded to Yalom’s (1995) therapeutic factors as important processes in group work with inmates, this research finding confirms that group therapists value group processes with inmates in building group relationship skills. We realize that group goals need to be specific to the presenting problems and types of inmates in therapy groups. However, some group goals for male inmates may be universal.

Given these eight important group goal factors, group therapists can use these overarching goals as a guide in developing group programs with male inmates. It is hoped that these goals will guide the future practice of group work with male inmates.

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