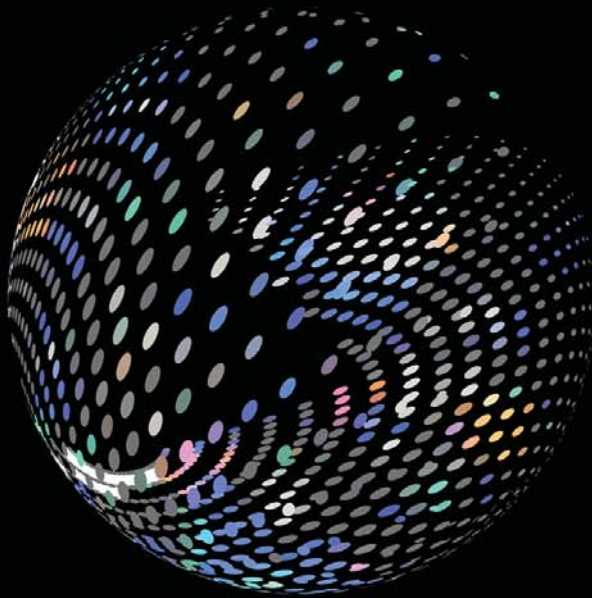


SECOND EDITION

Handbook of Social Work with Groups



**edited by Charles D. Garvin,
Lorraine M. Gutiérrez, and Maeda J. Galinsky**



ebook

THE GUILFORD PRESS

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About the Editors

Charles D. Garvin, PhD, is Professor Emeritus in the School of Social Work at the University of Michigan. His research interests include group work and social justice issues in social work. Dr. Garvin is the author or editor of several books, including *Group Work Research* and *Social Work and Social Justice*, as well as many journal articles and book chapters, and he served as coeditor of *Small Group Research*. A past chair and current board member of the International Association for Social Work with Groups, he is a recipient of the Significant Lifetime Achievement in Social Work Education Award from the Council on Social Work Education.

Lorraine M. Gutiérrez, PhD, is Arthur F. Thurnau Professor in the School of Social Work and the Department of Psychology at the University of Michigan, where she is also faculty associate in Latino Studies. Her teaching and scholarship focus on multicultural praxis in communities, organizations, and higher education. A Fellow of the American Psychological Association and the Society for Community Research and Action, Dr. Gutiérrez is a member of the editorial team of the *Journal of Community Practice*.

Maeda J. Galinsky, PhD, is Kenan Distinguished Professor Emerita in the School of Social Work at the University of North Carolina at Chapel Hill. She has published widely in the area of group work theory, practice, and research, including articles on support groups, open-ended groups, and evaluation of innovative interventions. Dr. Galinsky has served on the editorial boards of *Social Work with Groups*, *Small Group Research*, the *American Journal of Orthopsychiatry*, and *Social Work Research*, and on the board of the International Association for Social Work with Groups.

Contributors

Julie S. Abramson, MSW, PhD, School of Social Welfare, University at Albany,
The State University of New York, Albany, New York

Francheska Alers-Rojas, JD, Department of Psychology, University of Michigan,
Ann Arbor, Michigan

David Bargal, PhD, Paul Baerwald School of Social Work, The Hebrew University, Jerusalem, Israel

Allan Edward Barsky, JD, MSW, PhD, School of Social Work, Florida Atlantic University,
Boca Raton, Florida

Margot Breton, MSW, Faculty of Social Work, University of Toronto, Toronto, Ontario, Canada

Laura R. Bronstein, LCSWR, ACSW, PhD, Institute for Multigenerational Studies
and Department of Social Work, College of Community and Public Affairs, Binghamton University,
The State University of New York, Binghamton, New York

Justin Bucchio, PhD, Department of Social Work, Middle Tennessee State University,
Murfreesboro, Tennessee

Jillian Dean Campana, PhD, School of Theatre and Dance, University of Montana,
Missoula, Montana

Ruth Campbell, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Michael Chovanec, PhD, School of Social Work, St. Catherine University/University of St. Thomas,
St. Paul, Minnesota

David Córdova, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Sidonia Couto, MSW, RSW, Davenport–Perth Neighbourhood and Community Health Centre,
Toronto, Ontario, Canada

Jorge Delva, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Paul H. Ephross, PhD, School of Social Work, University of Maryland, Baltimore, Maryland

Janet L. Finn, PhD, Department of Social Work, University of Montana, Missoula, Montana

Dale Fitch, PhD, School of Social Work, University of Missouri, Columbia, Missouri

Maeda J. Galinsky, PhD, School of Social Work, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Larry M. Gant, PhD, School of Social Work and Penny W. Stamps School of Art and Design, University of Michigan, Ann Arbor, Michigan

Charles D. Garvin, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Alex Gitterman, EdD, School of Social Work, University of Connecticut, Storrs, Connecticut

Lorraine M. Gutiérrez, PhD, School of Social Work and Department of Psychology, University of Michigan, Ann Arbor, Michigan

Judy Hughes, MSW, PhD, Faculty of Social Work, University of Manitoba, Winnipeg, Manitoba, Canada

Barbara A. Israel, DrPH, Department of Health Behavior and Health Education, School of Public Health, University of Michigan, Ann Arbor, Michigan

Maxine Jacobson, PhD, independent consultant, Coeur d'Alene, Idaho

Brian L. Kelly, MSW, PhD, School of Social Work, Loyola University Chicago, Chicago, Illinois

Elizabeth Kiehne, MSW, School of Social Work, University of Arizona, Tempe, Arizona

Linda Farris Kurtz, DPA, ACSW, School of Social Work, Eastern Michigan University, Ypsilanti, Michigan

Paula Lantz, PhD, Gerald R. Ford School of Public Policy, University of Michigan, Ann Arbor, Michigan

Craig W. LeCroy, PhD, School of Social Work, Arizona State University, Tucson, Arizona

Mark J. Macgowan, LCSW, PhD, School of Social Work, Florida International University, Miami, Florida

Randy Magen, PhD, School of Social Work, Boise State University, Boise, Idaho

Carolyn M. Maker, LCSW, Department of Child and Adolescent Psychiatry, Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, Illinois

Andrew Malekoff, MSW, North Shore Child and Family Guidance Center, Roslyn Heights, New York

Flavio F. Marsiglia, PhD, School of Social Work, University of Arizona, Tempe, Arizona

Reuben Jonathan Miller, PhD, School of Service Administration, University of Chicago, Chicago, Illinois

Biren (Ratnesh) A. Nagda, PhD, IDEALeadership LLC, Seattle, Washington; Green String Network, Nairobi, Kenya

Helen Northen, MSW, PhD (deceased), School of Social Work, University of Southern California, Los Angeles, California

R. M. Ortega, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Desmond Upton Patton, MSW, PhD, School of Social Work, Columbia University, New York, New York

Brian E. Perron, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Susan Preston, MSW, PhD, School of Social Work, Ryerson University, Toronto, Ontario, Canada

Barbara Rittner, LCSW, PhD, School of Social Work, University at Buffalo,
The State University of New York, Buffalo, New York

Ronald Rooney, PhD, School of Social Work, University of Minnesota, Minneapolis, Minnesota

Jennifer Root, PhD, Lyle S. Hallman Faculty of Social Work, Wilfrid Laurier University,
Kitchener, Ontario, Canada

Steven R. Rose, MSW, ACSW, PhD, Department of Social Work, George Mason University,
Fairfax, Virginia

Mary C. Ruffolo, MSW, PhD, School of Social Work, University of Michigan,
Ann Arbor, Michigan

Izumi Sakamoto, PhD, Factor-Inwentash Faculty of Social Work, University of Toronto,
Toronto, Ontario, Canada

Christopher P. Salas-Wright, PhD, School of Social Work, Boston University, Boston, Massachusetts

Daniel G. Saunders, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Amy J. Schulz, PhD, Department of Health Behavior and Health Education,
School of Public Health, University of Michigan, Ann Arbor, Michigan

Rebecca Smith, PhD, Department of Social Work, Middle Tennessee State University,
Murfreesboro, Tennessee

Lee H. Staples, MSW, PhD, School of Social Work, Boston University, Boston, Massachusetts

Richard Tolman, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Ronald W. Toseland, PhD, School of Social Welfare, University at Albany,
The State University of New York, Albany, New York

John E. Tropman, PhD, School of Social Work, University of Michigan, Ann Arbor, Michigan

Barbara F. Turnage, PhD, Department of Social Work, Middle Tennessee State University,
Murfreesboro, Tennessee

Thomas V. Vassil, PhD, School of Social Work, University of Maryland, Baltimore, Maryland

Michael G. Vaughn, PhD, College of Public Health and Social Justice, Saint Louis University,
Saint Louis, Missouri

Michael R. Woodford, PhD, Lyle S. Hallman Faculty of Social Work, Wilfrid Laurier University,
Kitchener, Ontario, Canada

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Introduction

CHARLES D. GARVIN
LORRAINE M. GUTIÉRREZ
MAEDA J. GALINSKY

OVERVIEW OF THE BOOK

In this book we portray what we see as the critical dimensions of social work with groups, and we take a broad view of this domain of social work. We see it as encompassing any and all of the types of groups in which social workers participate as part of their professional activities, either as members or facilitators. This view of group work consequently incorporates groups that individuals of different age groups join to solve problems and attain their individual, administrative, and organizational goals, to enrich their lives, to ameliorate problems experienced by organizations and communities, to produce social change, and to promote social justice.

There are currently no books that fully portray this range of group work. This is undoubtedly due to space constraints imposed on texts, as well as limitations of books written by one or, at best, a few authors. A handbook such as this one, with multiple authors, is required to accomplish this purpose. Such a handbook should be a valuable resource for scholars and practitioners who seek information about any and all aspects of group work, including the knowledge base, the nature of existing models, the practice of group work in different organizational contexts, and the ways in which knowledge of group work can be increased through research. We do not believe that a single model of practice can encompass this range, and, therefore, we have commissioned chapters that explicate different models of practice as these are applied in various practice settings.

There has been a good deal of discussion as to what constitutes social work with groups and how this practice differs from the way other professionals, such as those in counseling and clinical psychology and psychiatry, offer group services. We believe that there is similarity in the ways that different human service professionals work with groups. We do not wish to define each profession's practice but only to assert what we regard as being social work with groups. We are also aware of a long tradition of referring to social work with groups as

social group work, and some writers have referred to contemporary practice that stems from this tradition as *mainstream practice* (Papell & Rothman, 1980). We think, however, that social workers, because of the many ways in which they offer group services, have developed many different group modalities.

Our position is that social work practice with groups conforms to the ethical guidelines of the profession, and this principle is expanded on in great detail in Chapter 5, inasmuch as there are issues that are central to ethical practice with groups. There are additional boundaries to social work practice with groups. One is that such practice emphasizes the importance of the quality of interactions among the members. These interactions are characterized by mutual respect and the recognition of the relationship of the individual to the group. Whenever appropriate to the purpose of the group, this quality includes the principle of *mutual aid*, which emphasizes members as helping one another. This principle draws on a vision of a democratic society in which individuals come to understand their interdependence. This extends to an emphasis on group work as one means to work toward social justice, and this theme is expanded on in Chapter 6.

Professional social workers who work with groups consequently seek to carry these ideas out in the groups they facilitate or in which they participate as social workers. Some groups, such as task groups that include committees, policy creation groups, and boards, may not emphasize the mutual aid concept so definitively when members are seeking to accomplish some purpose external to the group. Nevertheless, a social worker in such groups still seeks to help members to help each other in carrying out their individual tasks. In any case, however, social workers with groups must be aware of group development, which is how the groups evolve over time.

Group work often takes place in settings in which social workers are employed, because individuals benefit from working with others in groups to attain their goals. However, at times, others with whom they are compatible may not be available, they may fear the consequences of others knowing something particular about them that creates extreme vulnerability, or their current behavior may place other group members in some jeopardy. Whether some problem situations best lend themselves to a search for solutions in a group is a matter that is continuously being investigated.¹ Nevertheless, Alexis de Tocqueville (2000) said many years ago that he was impressed by the extent and strength of small-group associations in American life. In his own words:

Americans of all ages, all conditions, all minds constantly unite. Not only do they have commercial and industrial associations in which they all take part, but they also have a thousand other kinds: religious, moral, grave, futile, very general and very particular, immense and very small. Americans use associations to give fêtes, to found seminaries, to build inns, to raise churches, to distribute books, to send missionaries to the antipodes; in this manner they create hospitals, prisons, schools. (p. 489)

On the other hand, when dictatorships seize control of a country, one of their first acts is to ban or limit in other ways primary group associations.

In planning this book we sought to cover the following areas: (1) the knowledge base for group practice; (2) the variations in group work that are related to the cultures found in various parts of the world; (3) the value and philosophical premises of group work; (4) the major models of practice; (5) the ways practice differs when the purposes for creating groups varies and when it is conducted in different types of practice settings; (6) the varied use of

groups employed to further organizational or community purposes; (7) the issues faced by group work researchers and evaluators; and (8) the ways in which technological advances can be utilized in groups.

Consequently, we have organized this book into several sections related to these areas. Part I presents the intellectual bases of group work, especially in the social sciences, as well as in the realm of values, including the all-important value placed on empowerment. Social justice as part of group work is also a central issue, and a chapter on this is included in this section. We also present two chapters on the social science base: Chapter 1 focuses on content from group dynamics; Chapter 2 takes a systems and environmental context perspective. Other chapters provide a global perspective on group work and indicates that social work with groups is a major activity in all societies, although there are differences in how group work is conceptualized because of the various cultures and social and political conditions present in each society. It is significant to note that since the publication of the first edition of this book, the Association for the Advancement of Social Work with Groups has been renamed the International Association for Social Work with Groups, and each year additional countries (e.g., Lithuania, Ghana, and Germany) have joined the organization. Additional chapters in Part I describe the use of other important concepts, such as social justice and empowerment.

Part II presents two of the major models driving contemporary practice theory. One, referred to as the “mutual aid” model, focuses on the processes that occur in the group that promote members’ helping one another. The other, referred to as a “cognitive-behavioral model,” focuses on the ways that member behaviors and thoughts are altered by group interactions that model new behaviors and thoughts and reinforce or critique these so as to attain desired outcomes. We chose to highlight these models because we believe they are the most overarching and utilized models. There are, certainly, many other models of practice, such as task-centered, strengths-based, and narrative-oriented models. These are portrayed throughout this book as authors describe practices in various settings with various member populations. The two models discussed in Part II, however, seem to us to represent clearly different approaches to group work that require practitioners to think about their work in substantially different ways. Some workers do, however, seek to blend these ways.

Part III presents three types of groups that may be found in many settings but that require additional sets of practice principles. These are support and self-help groups, psychoeducational groups, and prevention groups.

Part IV contains chapters that describe group work in major practice settings with different populations and different types of behavioral and/or environmental issues. These include, for example, populations such as older adults, children, ex-offenders, and immigrants and issues such as mental health, substance abuse, interpersonal violence, child welfare, and intergroup conflict resolution.

Part V consists of chapters on groups formed to determine and implement organizational and community goals. These chapters are devoted to community collaboration, popular education, social action, team functioning, consumer empowerment, administrative groups, and a broadly based chapter on task group functioning.

Part VI consists of chapters on group research. Topics covered include intervention research, evaluation of practice, and measurement of variables in group work. The final part, Part VII, is devoted to the use of technology in groups.

CHAPTER STRUCTURE

We believe that effective group work requires its teachers and practitioners to draw upon many sources of knowledge about the ways people interact in groups. These sources, of course, include basic sciences such as psychology and sociology. In addition, other academic subjects, such as economics, political science, and anthropology, have contributed to our understanding of the context and dynamics of groups. Professions other than social work, such as nursing, psychiatry, and public health, also utilize groups, and we draw on their knowledge. The authors of chapters in this book were thus asked to draw on the wealth of knowledge found in many academic and professional sources,

We also assert that the emphasis on evidence regarding the effectiveness of group work practice is vital. Thus progress in developing practice principles and procedures is rooted in the experiences and reflections of practitioners and in the collection and analysis of quantitative and qualitative data by researchers about the impact of group work practice on members and their environments. We asked the authors to draw on all information about effectiveness of the topics of their chapters.

This emphasis is closely related to the development in many professions, especially medicine, of “evidence-based practice.” This practice affirms the idea that the practitioner should examine studies of the impact of a particular intervention before or as he or she uses it. A number of social work scholars have examined the utility of this type of practice, and we hope this book will extend the use of this practice in group work (Fraser, 2003; Gambrill, 1999, 2003; Garvin, Tolman, & Macgowan, 2016; Macgowan, 2006).

Since the pioneering work of writers such as Grace Coyle, Gertrude Wilson, Gladys Ryland, Hy Weiner, Clara Kaiser, and Alan Klein, group workers have been concerned with helping group members become more effective in challenging oppressive environments. In current terms, this process has been termed *empowerment*, and recently in all social work, and especially group work, there has been a strong emphasis on the effect of practice in achieving social justice. We have asked our contributors to attend to these issues, and we also, as noted, have separate chapters on empowerment, as well as social justice.

Lastly, we emphasized to the authors that they should deal with human differences such as culture, race, ethnicity, gender, and physical and mental abilities, as well as other sources of human variation, and how these are used to privilege some people and oppress others. We believe this issue is so central to group work that it should be universally and specifically attended to.

In summary, we asked the authors to write chapters based on the most recent ideas and research about their topics. We also asked them to incorporate a vision of the developments that they anticipate will occur in theory and practice, in social work and the social sciences and also in other fields of knowledge in the coming years. We supplied the following general outline for them to follow, although we recognized that the chapters would vary based on their specific foci:

1. Overview of the chapter
2. Description of the purpose of group work in context of the chapter
3. Interventions
4. Empirical evidence and theoretical base
5. Values
6. Examples
7. Future directions

NOTE

1. For a review of recent literature on this approach, see Ortega and Garvin (2016).

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PART I

THEORETICAL AND PHILOSOPHICAL FOUNDATIONS

INTRODUCTION

We group workers draw from many theoretical and philosophical frameworks to develop our practice principles. It would take a volume in itself to present all of these in depth. We have chosen, therefore, to highlight the main components of these frameworks in enough detail for the reader to understand these foundations and to assess the adequacy of practice paradigms in terms of their use of relevant theories, propositions, empirical findings, and social work ethics.

The first two chapters of this book present theoretical material from different standpoints. Chapter 1 presents important information from the field of group dynamics. This chapter discusses the theories that are used to understand the processes and other conditions that occur *within* groups, such as group development, the ways members influence one another, communication patterns, and group structures. Chapter 2 places the group within the broader sphere of the organizations and other systems that surround the group. This kind of understanding is necessary, as all groups influence their social environments and are, in turn, influenced by them.

The next four chapters in this section provide important value-related and other philosophical considerations that group workers should heed. Chapter 5, on ethics and values of importance to group work, portrays the ethical principles that distinguished social work practice with groups throughout its history.¹ This chapter considers issues that were not known to group work pioneers, issues that grew out of such contemporary phenomena as the current legal environment and the use of modern technology. A very important principle is that group work should be empowering to members as they take on changing oppressive conditions. We therefore commissioned a chapter devoted to empowerment issues in group work (Chapter 4). Since the first edition of this book, all social workers, including group workers, have seriously considered how group work can contribute to social justice. Chapter 6 deals with this topic.

We recognize that empirical knowledge and philosophy are responsive to the locale and the concomitant cultural context in which group work is practiced. Consequently, Chapter 3 examines group work practice and education as these occur around the world and portrays some of the similarities and differences in group work in different nations with differing needs, languages, and cultures. This fact is also reflected in the new name of the group work association, the International Association of Social Work with Groups, and the number of chapters of this association developing in many countries.

NOTE

1. In the first edition of the *Handbook*, Chapter 5 was written by Helen Northen who passed away in 2006. She influenced all of our thinking throughout her long career and we miss her and her wisdom. We are grateful that Allan Barsky himself a serious scholar of ethics undertook to update Chapter 5.

CHAPTER 1

Group Dynamics

RONALD W. TOSELAND

There are many theories about the development of group dynamics, but fundamental to all of them is the notion of groups as social systems. A system is composed of elements in interaction. When group members interact with each other, they form a social system, with attendant group dynamic processes. Group dynamics are the forces that emerge and take shape as members interact with each other throughout the life of a group. These dynamic forces are the product of both the here-and-now interactions of group members and what members bring to the group from the larger social environment.

THE IMPORTANCE OF GROUP DYNAMICS

An understanding of group dynamics is essential for effective practice with any type of task or treatment group. Failure to pay careful attention to group dynamics can lead to unproductive meetings and dissatisfied members. In extreme cases, such as the mass suicide at Jonestown, group dynamics gone awry can have serious consequences for individual members or the group as a whole. Group dynamics have important implications for individual members of the group, as well as for the accomplishments of the entire group. Groups that do not consider cultural, ethnic, and racial variables risk injuring diverse members. Therefore, throughout this chapter we consider the impact of these variables on group dynamics.

To practice effectively with groups, social workers should be able to (1) understand group dynamic processes as they emerge during the ongoing interaction of group members, (2) consider the impact of these dynamics on members from diverse backgrounds, (3) assess the impact of emerging dynamics on current and future group functioning, and (4) guide the development of group dynamics that facilitate member participation and satisfaction while enabling the whole group to accomplish its goals.

CONCEPTUALIZING GROUP DYNAMICS

Group dynamics can be conceptualized as falling within the following five domains: (1) communication processes and interaction patterns, (2) interpersonal attraction and cohesion, (3) social integration and influence, (4) power and control, and (5) culture. A conceptual framework of group dynamics is an important heuristic device for workers seeking to assess and understand how any group works. A conceptual framework enables workers to identify and understand group dynamics as they emerge during interaction. Since the 1940s, many scholars have attempted to conceptualize and categorize group dynamics. Some of the most notable include Bales and colleagues (Bales, 1950; Bales, Cohen, & Williamson, 1979), Cartwright and Zander (1968), Forsyth (2014), Hare, Blumberg, Davies, and Kent (1995, 1996), Lewin (1951), McGrath (1984), Nixon (1979), Olmstead (1959), and Parsons (1951). The conceptualization of group dynamics presented in this chapter is based on the work of Toseland and Rivas (2017) but draws heavily on the work of these scholars. The chapter gives special attention to racial and ethnic variations so that group work practitioners can develop and lead effective multicultural groups. Because group dynamics are not static over the life of the group, they change as the group develops; thus this chapter also includes a section on models of group development.

COMMUNICATION PROCESSES AND INTERACTION PATTERNS

Communication processes and interaction patterns are fundamental group dynamics. They are the components of social interactions that influence the behavior and attitudes of group members. As a process, communication involves the transmission of a message from a sender to a receiver. According to Toseland and Rivas (2017), communication includes (1) the encoding of perceptions, thoughts, and feelings into language and other symbols by a sender; (2) the transmission of language and symbols verbally, nonverbally, or virtually; and (3) the decoding of the message by the receiver.

Communication can be verbal, nonverbal, or virtual. Members of in-person and video groups experience both verbal and nonverbal communications, whereas members of telephone groups experience only verbal communications, and members of computer groups experience only virtual communication. Communication can also be synchronous (i.e., back and forth in real time) or asynchronous. Asynchronous communications occur in computer groups in which members may respond to messages long after they are posted.

Whenever group members are communicating, they are sending messages that have meanings. Effective leaders listen hard for the meaning in messages. In in-person and video groups, members are always communicating, because even if they are not communicating verbally, their nonverbal behavior is observable and is communicating something. In telephone and computer groups, nonverbal communication is absent. The greater anonymity due to the lack of face-to-face contact in telephone and computer groups has important implications for the way members communicate in these groups. For example, it has been pointed out that salience of race and socioeconomic issues is reduced and greater privacy is afforded to stigmatized individuals (Glueckauf, & Noel, 2011; Page, 2010). A discussion of distance groups and how to lead them can be found in Toseland and Rivas (2017).

Although meaning is communicated in every message, it is important for workers to be aware that problems in sending or receiving messages and transmission problems can distort

or obfuscate the intended meaning of messages. For example, the sender of a message may be unclear or ambiguous. The receiver of a message can suffer from selective perception or completely block out a message. Communication can also be distorted in transmission. Noise and other distractions within or outside of the meeting room (or on computers or telephones) can cause distortions.

Language barriers and the interpretations of the meanings of messages can interfere with effective communication in groups. Language often reflects social attitudes. It shapes thoughts and attitudes and guides thinking patterns and the expression of ideas. The role that language plays in human interaction among majority members and members from minority backgrounds should be carefully monitored by the group worker. It is essential not to repeat any form of marginalization, neglect, or oppression in the group. Group dynamics should foster harmony and understanding among people from diverse backgrounds. Any form of overt or subtle discrimination based on culture, disability, ethnicity, gender, sexual preference, or racial background should be addressed. Groups should strive to promote harmony and understanding to enable all members to attain optimal health and well-being. For example, Gray-Little and Kaplan (2000) pointed out that European Americans had a significantly higher rate of verbal participation in groups than did Asian Americans, Native Americans, and Mexican Americans of similar educational background. Privileged status should not be mirrored in workers' leadership of groups. Because higher levels of participation may reduce attrition, yield greater changes in self-esteem, and reduce questions about the value of involvement in groups, lower levels of verbal participation raise troubling questions about therapeutic outcomes for marginalized members of groups. To avoid this, workers should enable all members to participate fully.

Special care should be taken to avoid misunderstandings of messages sent and received by members whose native tongue is not English (Diller, 2015). In addition to accents and dialects that can sometimes interfere with clear communication, the meanings of many words are culturally defined. Thus care should be taken to clarify the meanings of messages in groups with members from different cultural and racial/ethnic backgrounds.

The most effective way to ensure that the meaning of the sender is understood by the receiver is for the worker to ask for feedback from the receiver. This ensures that the receiver and all other members understand the meaning of the messages in similar ways. Nonverbal cues can often be one way for perceptive group workers to identify when one or more members may have some difficulty with the transmission or the content of particular messages. Statements such as "Did I understand you correctly?" or "Let me make sure I understand what you are saying" help to prevent distortions in communication. Toseland and Rivas (2017) suggest that effective feedback should (1) describe the content of the communication as it is perceived by the member, (2) be given to the member who sent the message as soon as the message has been received, and (3) be expressed in a tentative manner so that it is clear that the feedback is intended to clarify the original message rather than confront or attack the sender.

Interaction patterns are also fundamental group dynamic processes. Some common interaction patterns include (1) the maypole, in which the leader is the central figure and most communication occurs from member to leader or leader to member; (2) the round robin, in which members take turns talking; (3) the hot seat, which features extended interaction between the leader and a member; and (4) the free-floating pattern, in which all members freely communicate. In most therapeutic groups, group-centered rather than leader-centered interaction patterns are valued because they help to ensure the full participation of

all members. Unfettered and open communication patterns are also helpful in task groups such as teams, in which reciprocal interdependence often warrants decentralized communication (Forsyth, 2014).

Interaction patterns are affected by members' proclivity to communicate. Some members are more outgoing than others and take more opportunities to communicate. Interaction patterns are also affected by verbal and nonverbal cues. Praise and other supportive comments, eye contact, and other expressions of interest tend to elicit more communication. The status and power relationships within the group also affect interaction patterns. Higher-status members tend to communicate more than lower-status members. Interpersonal attraction and the emotional bonds that form between members also influence interaction patterns. For example, members of subgroups tend to interact more with each other than with other group members.

The size of the group also affects interaction. In general, the smaller the group, the more chance there is for each member to communicate. Physical arrangements can also have an important impact on interaction patterns. Many factors, such as how chairs are arranged, whether a conference table is used, the size of the room, and whether the environment is comfortable and private should be considered.

Workers may want to reduce communications from talkative members or encourage reserved members to talk more. Pointing out interaction patterns is often sufficient to bring about change, but other methods may also be used. For example, reserved group members may benefit from go-rounds, because it gives them the opportunity to speak when it is their turn. Selective attention, clues, and reinforcement also can be used to change interaction patterns. By acknowledging and praising selected communications, workers can draw out reserved members. By directing communication to others, workers can reduce the communication of dominant members. Giving members specific roles or tasks, changing seating arrangements, and asking members to break into subgroups are other methods that can be used to change interaction patterns.

Subgroup formation occurs naturally in all groups because members do not all interact with equal valence. Interpersonal attraction, emotional bonds, and interest alliances are stronger among some members than others. Subgroups can take the form of dyads, triads, or cliques. Also, there can be isolates, who are not attached to subgroups, and scapegoats, who receive negative attention and criticism from the group. Subgroups usually are not a problem in groups unless such a strong alliance is formed among subgroup members that it threatens to supersede their allegiance to the group as a whole.

An important process in group work is changing the way individuals accept and interact with each other. This change can be accomplished by helping members to increase their personal honesty and to become more aware of their own attitudes and feelings toward people who are different from them. Groups can be structured so that minority members feel comfortable and do not have their values ignored, minimized, or challenged. Developing norms that celebrate and embrace diversity are one way to accomplish this objective. Promoting social equality and justice and encouraging the empowerment of all members through open communication and dialogue are core values of social group workers.

INTERPERSONAL ATTRACTION AND COHESION

Interpersonal attraction contributes to subgroup formation and to the level of cohesion of the group as a whole. Several factors contribute to interpersonal attraction. Proximity

increases interaction among people, which, in turn, often increases attraction. Therefore, just the physical act of meeting together helps to form bonds among members. However, proximity alone is usually not sufficient for interpersonal attraction to occur. In research done more than a half a century ago, Newcomb (1960, 1961, 1963) showed that interpersonal attraction is fostered by similarity (i.e., we tend to like people who are similar to us). We can also be attracted to people who are dissimilar to us if they complement our personal qualities in some way (Forsyth, 2014).

Other factors also contribute to interpersonal attraction—for example, acceptance and approval. Thus group members who are accepting and positive and those who praise others for their contributions tend to be viewed as interpersonally attractive. Reciprocity also frequently operates in these situations, so that positive accepting behavior begets positive, accepting responses.

Compatibility in member expectations also tends to promote interpersonal attraction. Members are often attracted to those who engage in group interactions that meet their expectations. For example, if high disclosure is expected, a member who discloses deeply is more likely to be found to be interpersonally attractive than a member who is reserved. Similarly, members who fulfill the unmet needs of others in the group will also frequently be found to be interpersonally attractive. For example, if the group desires a strong leader, the member who demonstrates strong leadership capacities is generally viewed as interpersonally attractive by the other members of the group.

Group cohesion is the sum of all the forces that are exerted on members to remain in the group (Festinger, 1950). Interpersonal attraction is just one of the building blocks of group cohesion. In addition to interpersonal attraction, other factors contributing to cohesion include (1) satisfaction of members' needs for affiliation, recognition, and security; (2) resources and prestige that members believe will be garnered through group participation; (3) expectations about the beneficial consequences of the work of the group; and (4) positive comparison of the group with previous group experiences (Cartwright, 1968).

Groups satisfy members' needs for affiliation, recognition, and security in many ways. Individuals who are lonely or isolated, for example, often find that groups provide opportunities for socialization that are unavailable to them in other contexts. People are also attracted to groups that recognize their accomplishments, that foster their sense of competence, and that build their self-esteem. Similarly, when members' contributions are valued and when they feel that they are well liked by the other members of the group, they are more likely to place a high value on participating in the group. Satisfying members' needs can also mean providing culturally and contextually relevant information. For example, a group worker provides an African American single-parent father with culturally relevant parenting information, and other members mention affordable and high-quality child care agencies that they know about in the community. Here, the sharing of relevant information validates unique multicultural parenting needs while reinforcing mutual aid and cohesion within the group.

Access to resources and prestige also tends to make groups cohesive. Groups that give members access to resources they might not otherwise have are attractive. Members may develop new contacts with high-status members who might also help them outside of the group. Being a part of a group that has the power to make important decisions can raise members' status and prestige in the community. Cohesion is also enhanced when members feel that they are working on important issues that they can influence. Conversely, when members feel that their input is being ignored or that it is ineffectual, they are not likely to feel strongly connected to the group or the people in it.

Members tend to compare their experiences in a group with their experiences in other groups. When studying cohesion in groups, Thibaut and Kelley (1959) found that members' continued desire to stay in a group was based on the satisfaction derived from participating in the group compared with other alternatives, what they called the "comparison level for alternatives." Thus members who are satisfied with a group and who do not think that they will be more satisfied participating elsewhere will tend to remain committed to the group.

Members' reasons for being attracted to a group affect how they act in it. For example, members who are attracted to a group primarily because of the prestige it brings to them are not likely to initiate controversial or difficult topics that might affect their status in it. Similarly, members who join a group primarily for the opportunity it provides for social interaction tend to engage in more off-task conversations than those who join a group because of the important work it is charged to accomplish.

The level of cohesion in a group also influences members' behaviors in many different ways. High levels of cohesion have been associated with many beneficial member behaviors, such as greater (1) perseverance toward group goals, (2) willingness to take responsibility for group functioning, (3) willingness to express feelings, (4) willingness to listen, and (5) ability to use feedback and evaluations (Toseland & Rivas, 2017). High levels of group cohesion have also been associated with positive outcomes for individual members and the whole group. These include (1) greater satisfaction with the group experience; (2) higher levels of goal attainment by individual group members and the group as a whole; (3) greater commitment to the sponsoring organization; (4) increases in members' feelings of self-confidence, self-esteem, and personal adjustment; and (5) higher levels of meeting attendance and an increased length of participation.

Despite the many beneficial aspects of high levels of group cohesion, it can also have some negative consequences. High levels of cohesion can lead to dependence on the group. Cohesion can also lead to a level of conformity that detracts from the work of the group. For example, members may remain silent rather than share helpful information, ideas, and thoughts because they believe these may be contrary to what the majority wants to hear. Conformity can become pathological when members' fears of losing status or being ostracized prevent them from voicing innovative but unpopular ideas or from raising the possibility that negative consequences may result from actions being contemplated by the group. Janis (1972, 1982), for example, noted that pathological cohesion is one ingredient of groupthink. The members' striving for unanimity and acceptance within the group can become so great that it overrides their motivation to think independently and to realistically appraise alternative courses of action. Therefore, while promoting group cohesion, workers should strive to preserve members' individuality. Workers can do this by guiding groups to develop norms that encourage the free and open expression of ideas and opinions and that value the expression of divergent opinions and ideas.

SOCIAL INTEGRATION AND INFLUENCE

Social integration refers to how members fit together and are accepted in the group. Norms, roles, and status are group dynamics that promote social integration by influencing how members behave. These dynamic processes set out members' places within the group. They lend order and familiarity to group processes, helping to make individual member's behaviors predictable and comfortable for all. Norms, roles, and status help groups to avoid excessive conflict and unpredictability, which can, in turn, lead to chaos and the disintegration of

the group. Groups cannot function effectively without a fairly high level of social integration of members. Social integration helps to build unanimity about the purposes and goals of the group, helping the group move forward in an orderly and efficient manner to accomplish work and achieve its goals.

Norms are shared beliefs, expectations, and understandings about what constitutes acceptable, appropriate, preferred, and valued ways to behave in groups. Norms develop gradually as the group meets. Therefore, they are not necessarily the same thing as the “rules” that are sometimes formulated in the first meeting. Rules are suggestions about how to behave that are developed by workers and members. Rules, however, do not become norms until they actually govern the behavior of members. Some rules become norms as the group develops and as they are followed by members and the worker. Others, however, may not be followed in the group and, therefore, never become norms. For example, there may be a rule about coming on time, but unless this rule is reinforced and followed, it may not become the norm, and members may start participating at different times. Having this rule become a norm might involve the worker intervening by being vigilant about starting each meeting on time and refusing entry to members who are more than 5 minutes late.

Norms can be overt and explicit or covert and implicit. A group worker who states that the group will begin and end on time and then follows through on starting and ending on time each week is developing an explicit group norm in an overt fashion. In contrast, a covert, implicit norm might develop in a couples group in which members avoid any discussion of infidelity or sexual satisfaction with their partner. The norm is “we don’t talk about those kinds of things in this group.”

Norms vary by the extent to which they are perceived to be binding on all members of the group. When a norm is highly binding, violating it often means severe sanction. For example, a highly binding norm may be that members do not engage in heated arguments. Norms also vary by their degree of salience for individual members. Some members may perceive a particular norm as important, whereas others may perceive it as only optional. For example, a member may find it uncomfortable or offensive if another member sits in the seat that the first member has been sitting in for the previous several weeks, whereas other members may not care if seating arrangements are changed.

Norms develop gradually as members experience what is valued and preferred behavior through group interaction. Therefore, it is important for workers to be cognizant of the development of norms, especially in the first few meetings. Among workers’ most important roles is guiding the development of norms that are satisfying and that promote work while helping groups avoid developing norms that will reduce member satisfaction or prevent the group from achieving its goals. Workers can share perceptions about group norms and suggest ways in which norms could be changed to promote the growth of the group and its members. It can also be very helpful to spend a few minutes at the beginning or end of meetings to discuss desired norms and how to achieve them.

Roles describe how each member will behave in relationship to the work of the group. At their best, roles help to ensure a division of labor when working on group goals. Members can take on many different roles in a group. Many years ago, Benne and Sheats (1948) developed a typology of group roles that included (1) task roles, such as the coordinator and the information seeker; (2) social-emotional roles, such as the encourager and the harmonizer; and (3) individual roles, such as the silent member and the scapegoat.

Special attention should be given to norms that are inclusive and empowering of all members. When groups include a diverse membership, all members should feel included and valued. Marginalization, oppression, stigmatization, and other interactions that devalue

any member should not be a part of any social work group. Social group workers have the responsibility to ensure that members do not feel devalued or ignored. Sometimes, the feeling of devaluation can develop in subtle ways. Being the only racial/ethnic minority member, for example, can be isolating and may even cause the member to feel pressured to agree with the majority. Social group workers should encourage norms and roles that welcome all members to actively participate. In some situations, this may include changing the composition of the group so that greater balance or more diversity is included in the membership.

It is helpful for the group to have some members who take on roles that facilitate task accomplishment and other members who take on roles that meet members' socioemotional needs. Thus members who keep the group on task, who are empathic, and who inject humor all help the group to develop in a positive fashion. Members who take on other roles, such as monopolizers, jesters, scapegoats, or aggressors, can be problematic for the effective functioning of the group. Workers should take the time to analyze the roles that members play in the group and help members to take on roles that promote social-emotional satisfaction with participation and feelings of goal accomplishment.

Status refers to the ranking of importance of members of the group relative to each other. Status is determined by the prestige, power, position, and expertise members bring with them to the group and by the contributions members make to the ongoing work of the group. Because a group member's status is measured in relationship to other members, it may change when other members join or leave the group. Status is also determined by the situation. Members' status may change depending on the extent of their contributions to various aspects of the work of a group. For example, when a group is focused on health issues, the status of a group member who happens to be a nurse may increase.

Status hierarchies have a good deal of influence on social integration within groups. For example, low-status members are the least likely to conform to group norms and to perform up to role expectations because they have less to lose by deviating from expected behavior. Therefore, low-status members have the potential to be disruptive of productive group processes. The leader should provide opportunities for low-status members to contribute to the group so that they can become more socially integrated and achieve a higher status. Medium-status members tend to conform to norms and roles so that they can retain their status or achieve a higher status. High-status members generally conform to norms and role expectations when they are establishing their position, but they have more freedom to deviate from established norms once their high-status positions are established. Thus high-status members can be an important force in changing norms that are counterproductive for achieving group goals.

Norms, roles, and status are important components of the social influence that groups have on members. The well-known early studies by Sherif (1936), Newcomb (1943), and Asch (1952, 1955, 1957) clearly demonstrated that the views of individual group members are influenced by majority opinion. Members with minority points of view, however, can also influence the majority. In a series of experiments, Moscovici, for example, showed that a small number of vocal and persistent group members were able to have some influence on the views of the majority who held differing opinions (see, e.g., Moscovici, 1985, 1994).

Forsyth (2014) has pointed out that those with minority opinions are more likely to be heard if they (1) offer compelling and consistent arguments, (2) are assertive about the importance of listening to their opinions, (3) appear confident rather than rigid or close-minded, (4) are flexible and able to grant small concessions to the majority, and (5) confront majorities that are not certain about their positions. Therefore, members with minority

opinions can have an important voice when their arguments are well reasoned and persuasive, especially in groups in which open-mindedness is a valued norm.

POWER AND CONTROL

Power and control can be uncomfortable subjects for social workers, who may prefer to talk about their work in terms of empowerment, facilitation, mediation, mutual aid, partnership, or relationship building. Despite this, the power of the designated leader of a group is undeniable. French and Raven's (1959) classic analysis suggests that leaders can draw on seven power bases: (1) connection power—the ability to draw on the resources of influential people and organizations; (2) expert power—having the knowledge to help the group achieve a particular goal; (3) information power—possessing information that is needed by the group; (4) legitimate power—holding an official position and the authority, rights, and privileges that go with that position; (5) reference power—being liked and admired by group members; (6) reward power—the ability to offer social or tangible rewards; and (7) coercive power—the ability to sanction, punish, or deny access to resources, rewards, and privileges.

The power and control of group leaders are especially visible in early group meetings, when members direct most of their communications to the leader rather than to each other. Still, the power of leaders should not be underestimated at any point in the life of a group. In a series of laboratory experiments, Milgram (1974) showed that people will follow orders given by authority figures even after they are given cues that following orders might cause harm. The group worker should pay particular attention to the role of power in the lives of group members who have suffered neglect, marginalization, or oppression in the community. Those living in poverty, members of minority groups, those with mental and physical disabilities, and those being discriminated against because of sexual preferences or other reasons are particularly vulnerable. Power is very important to these members because it has been used to diminish their humanity in many ways since birth. Therefore, group workers should do all they can to enable these members to speak for themselves and have the opportunity to participate fully in the group. Special accommodations may need to be made for people with disabilities. Encouraging full participation includes encouraging marginalized members with low self-esteem to have a voice in how the group is conducted.

In multicultural groups, it is important for workers to be aware of how they manage feelings, perceptions, and attitudes about power and authority in relation to their own group status. Workers' lack of understanding of the power dynamics that members face outside of the group can negatively affect relationships with members and the resulting group processes and outcomes. If facilitated inappropriately, heterogeneous multicultural groups run the risk of reenacting oppressive dynamics of invalidation and disempowerment. To avoid this, group workers should be sensitive to feelings of alienation, devaluation, and oppression caused by the unequal justice and violations of human rights experienced in the community setting (Ife, 2012). Insensitivity by the worker sends a message to minority group members that they are not understood and that the group can't be helpful. It is important that group workers develop self-awareness and also promote empowerment and self-care. This can help to reduce internalized feelings of a devalued and powerless ethnic/racial identity among members of minority and other groups who are victims of discrimination and oppression outside of the group (Burnes & Ross, 2010; D'Andrea, 2014; Ratts & Pedersen, 2014; Shah & Kosi, 2012; Singh & Salazar, 2010).

A certain amount of power and control is needed in groups to maintain orderly and efficient group meetings and motivated members. Leaders, for example, can use power and control constructively by helping the members to overcome motivational problems. Members can lose motivation for many reasons, but three of the better known reasons are social loafing, free riding, and the sucker effect (Levi, 2014). *Social loafing* is a term used to describe a reduction in individual motivation and contributions when people are working in a group rather than alone (Latané, Williams, & Harkins, 1979). Those who think their contributions are not important and who know they will receive their share of the rewards regardless of their level of input have been called *free riders* (Sweeney, 1973).

There is also the *sucker effect*, in which good performers slack off so as not to be taken advantage of by those who are less talented or less motivated (Johnson & Johnson, 2000). Leaders can set up incentive systems and use other power and control mechanisms to help avoid these motivational problems. For example, social loafing and free riding can be avoided or undone by increasing a member's personal stake in the group. To do this, leaders can help members to perceive the meaningfulness of the task, how they will personally benefit from being actively engaged, and how their active engagement will benefit others. Making the group smaller, clarifying group rules, setting high standards, being a role model, helping members to believe that their fellow group members are capable and willing to contribute, and helping the group as a whole to feel that it is efficacious are some other ways to reduce social loafing and free riding.

Power and control are often associated with the designated leader, but, to ensure the active involvement and commitment of members, it is essential for designated leaders to share power and control as the group progresses. This principle recognizes that members also can have power and control over each other. Toseland and Rivas (2017) suggest that this can be done by (1) encouraging member-to-member rather than member-to-leader communications, (2) ensuring that members have input into the agenda for group meetings and the direction the group will go in future meetings, (3) supporting indigenous group leaders as their attempts at leadership emerge during group interaction, and (4) encouraging attempts at mutual sharing and mutual aid among group members. Members can also be empowered by encouraging them to take on leadership roles in subgroups that work on specific tasks between meetings, by recognizing their special skills and talents, and by praising and rewarding them for their active involvement in the work of the group.

Early studies of group leadership emphasized the benefits of democratic leadership as compared with autocratic and laissez-faire leadership (Lewin & Lippitt, 1938; Lewin, Lippitt, & White, 1939). Over the years, leadership studies have become more sophisticated. Transactional models of leadership that emphasize rewards, punishments, cost-benefit ratios, and the coercive power of "the carrot and the stick" were developed. These models have largely been replaced with charismatic and transformational leadership models (Avolio, Walumbwa, & Weber, 2009; Forsyth, 2014). The components of transformational leadership include (1) vision, (2) inspiration, (3) role modeling, (4) intellectual stimulation, (5) meaning making, (6) appeals to higher-order needs, (7) empowerment, (8) setting of high expectations, and (9) fostering collective identity (Conger, 1999).

Transformational leadership models emphasize the role of the leader as a charismatic role model who helps members to overcome self-interest and perceive larger group and organizational goals (Alimo-Metcalfe & Alban-Metcalfe, 2001; Avolio et al., 2009; Forsyth, 2014). Transformational leaders encourage member autonomy and individuality in pursuing group and organizational goals. They encourage members to question assumptions, to approach problems and old solutions in new ways, to reframe problems as opportunities,

and to be creative and innovative problem solvers. Transformational leaders use power, but they do so while inspiring members with visionary leadership as to what is possible. They appeal to members' altruistic motives to transcend their own self-interests to get the goals of the group accomplished (Diaz-Saenz, 2011). Transformational leaders are focused on inspiring and empowering members rather than on inducing compliance (Diaz-Saenz, 2011). For example, a study of 47 work groups suggested that transformational leadership is associated with empowerment of members, cohesiveness, and perceived group effectiveness (Jung & Sosik, 2002). Other literature also suggests that the most effective leaders are charismatic individuals who promote safe, welcoming group environments that avoid the extremes of aggressive confrontation of members or passive abdication of leadership to aggressive group members (Forsyth, 2014; Kivlighan & Tarrant, 2001).

CULTURE

The culture of a group is defined by the values, beliefs, customs, traditions, and preferred ways of doing business that are implicitly understood and shared by all group members. Deeply held beliefs and assumptions that define a group culture emerge through interaction over time. The values, preferences, and interpersonal styles of individual members that come from their ethnic, cultural, and racial heritage, previous life experiences, and genetic disposition have to be blended together before a group culture develops. As members meet, they explore their value systems and interpersonal styles, searching for a common ground on which to relate to each other. Valuing members from diverse backgrounds involves facilitating an exploration of their ethnic and racial heritages and experiences, their attitudes about themselves, and how these attitudes and feelings affect their functioning. It also involves leaders' actively generating a set of group norms that are consonant with the cultural values and perspectives of all group members (D'Andrea, 2014). As a result of this process, a common set of assumptions, values, and preferred ways of doing business emerges, forming the group's culture.

Levi (2014) views culture as having three levels of depth. On the surface level are symbols and rituals that display the culture of the group. At a deeper level, culture is displayed in the styles and approaches that group members use when interacting with each other. For example, the way conflict or competition is handled in a group says much about its culture. The deepest level of culture consists of core ideologies, values, and beliefs held in common by members of the group (Levi, 2014).

The culture of a group is also determined, in part, by the sponsoring organization, the community, and the larger society. Groups take on some of the dominant values and traits of these larger social systems. The influence of these systems depends on the nature and extent of their interactions with the group. When a group is dependent on an organization for its sanction and its resources, it is particularly likely to take on the dominant culture of the organization. For example, a team or a governance committee is more likely to take on the culture of an organization than is a self-help group sponsored by the same organization. Similarly, a sports team sponsored by a neighborhood community center is more likely to take on the cultural values of the larger society than is a gang that meets in a private location.

Multicultural differences are also salient interpersonal factors that have significance for the group culture. Traditionally, group processes have reflected the European and American values of individualism, independence, competitiveness, and achievement. These values are

different from the values of humility and modesty that are dominant in some other cultures. A potential consequence is the worker's insensitivity to group members with other racial/ethnic backgrounds. This insensitivity has the potential to negatively affect group dynamic processes in the whole group.

Racially and ethnically diverse groups tend to have their own cultural attributes, values, and experiences because of their unique histories. Cultural experiences of group survival, social hierarchy, inclusiveness, and ethnic identification influence the way members interact with one another in the group. To be effective with all group members, workers should be sensitive to racial/ethnic and socioeconomic differences, should understand the effect of these differences on group dynamics, and should translate this knowledge into culturally sensitive methods of program development and leadership (Toseland & Rivas, 2017).

A distinct culture tends to emerge more quickly in groups that are homogeneous. When members share similar values and life experiences, their unique perspectives blend more quickly than in groups with diverse membership. For example, a caregiver support group made up of the spouses of frail veterans tends to form a distinct culture more quickly than does a caregiver support group made up of both spouses and adult children who are caring for frail older persons who have not all shared military service. Once a culture has developed, members who endorse and share in the group culture feel comfortable, but those who do not feel isolated and alienated. For the isolated member, the group is not a very satisfying experience. Isolated members are more likely to leave the group because it does not meet their social-emotional needs. Feeling misunderstood and left out is demoralizing and depressing. More extreme feelings of alienation can lead to rebellious, acting-out behavior. For subgroups that are not part of the dominant culture, feelings of isolation are often equated with feelings of oppression. Subgroups that feel repressed are likely to rebel in various ways against the norms, roles, and status hierarchies that have been established in the group. By providing individual attention to isolated members and by stimulating all members to consider values that transcend individual differences, leaders can foster the full participation and integration of all group members into the life of a group.

GROUP DEVELOPMENT

As groups develop over time, group dynamic processes evolve. Many attempts have been made to conceptualize these changes in stage models of group development. There is, for example, the well-known model by Tuckman (1963): (1) forming, (2) storming, (3) norming, and (4) performing. There is also the widely used model by Garland, Jones, and Kolodny (1976): (1) preaffiliation, (2) power and control, (3) intimacy, (4) differentiation, and (5) separation. For a more complete list of some of these models, see Toseland and Rivas (2017).

Beginning stages of group development are characterized by the formation of all five categories of group dynamics. At first, members interact tentatively. Gradually, communication patterns, norms, roles, and status hierarchies are established, and a group culture slowly emerges. At first, the interaction is tentative and cautious, with little conflict. Then, as members become more comfortable and emboldened, conflict and resistance can occur. Members want to become a part of the group but at the same time maintain their own identities and independence. While becoming socially integrated, members explore and test roles, and they challenge developing norms and status hierarchies.

Encountering some conflict is normal, and dealing with it is an important skill for group workers. Conflict resolution strategies can be found in many sources (see, e.g., Fisher,

Ury, & Patton, 2012; Forsyth, 2014; Rooney, 2009; Schimmel & Jacobs, 2011; Toseland & Rivas, 2017). For instance, if racism is perceived in the early stages of group development, cross-cultural issues can be frightening to explore. Anxiety experienced by group members often fosters stereotypical thinking and ego states that are representative of less mature development. Group members often look to the leader to resolve the group's discomfort. In this case, group leaders should promote interpersonal skills in ways that build mutual connection and create norms that facilitate an exploration of these difficult issues.

The middle stages of groups are characterized by an emphasis on work. Energy devoted to developing cohesive group functioning and comfortable norms and productive roles in earlier group meetings gives way to productive interaction during the middle stage of the life of a group. Words such as *performance* and *problem solving* are frequently used in models of group development to convey the emphasis in the middle stage on work and goal achievement.

The ending stages of group development focus on the completion of remaining tasks. Evaluations of the work of the group are conducted, and ending ceremonies are planned. Task groups finish their business, make decisions, and produce the results of their efforts. Therapeutic groups help members to reduce their emotional attachment to the group. They also focus on methods for maintaining positive changes made during the group after the group ends. While accomplishing these tasks, norms and roles may change, and the group's culture matures.

Stage models of group development are helpful in providing guidance to workers about what might occur as a group develops. At the same time, each group is unique. Many factors affect a group's development. Structural characteristics, such as whether a group is time limited or has an open or closed membership, have an important impact on development. Similarly, the capabilities of group members and the support of the sponsoring organization can also affect group development. Therefore, workers should not assume that all groups follow the same developmental pattern. Stage models of group development are good heuristic devices for understanding how group dynamics may evolve over time, but the actual unfolding of group dynamics in a particular group can only be ascertained by careful observation or by using one or more of the measures described in the following section.

MEASURING GROUP DYNAMICS

The measurement of group dynamics is essential in understanding the behavior of members and of the whole group (Burlingame, Strauss, & Joyce, 2013). Over the past three decades there have been many reviews of group process and outcome instruments (i.e., Delucia-Waack, 1997; Fuhriman & Barlow, 1994; Fuhriman & Packard, 1986; Macgowan, 2008; Sandano et al., 2014; Schwartz, Wald, & Moravec, 2010). These instruments have been described as useful in analyzing group therapy processes, group climate and therapeutic dimensions, and interactions among group members. In this section, we present a brief sample of group dynamics measures to acquaint group workers and researchers with some of the available measures of group processes. Our selected descriptions are intended to be introductory, thus permitting readers to choose measures, review them in further detail, and apply the most suitable instruments for their group work needs.

Barlow (2010, 2013), Forsyth (2014), Macgowan (2008), and others describe a variety of observational methods available to the group work practitioner. Some practical measurement methods that involve observing and recording of individual and group behaviors

include participant observation and structured observational measures. One useful measurement system is interactional process analysis (IPA), developed by Bales (1950). IPA is a structured coding system for classifying behaviors among group members and is delineated by task and social-emotional activities. Forsyth notes that IPA is valuable because it reports the frequency of occurrences of behavior of group members.

Group cohesion, engagement, and level of trust can be measured with the Group Climate Questionnaire (MacKenzie, 1983), a brief 12-item measure consisting of three scales: Engagement, Differentiation, and Individuation. The Group Cohesiveness Scale (Budman, Soldz, Demby, Davis, & Merry, 1993) explores group connectedness and openness to self-disclosure and consists of six subscales (Withdrawal, Interest, Trust, Cooperation, Expressed Caring, and Focus) and one global scale (Cohesiveness). Another instrument is the Groupwork Engagement Measure (Macgowan, 1997, 2000). It consists of a 37-item scale composed of seven dimensions: group member attendance, contributions, relations to members and to worker, contracting, and working on own and other members' problems.

There are also tools to measure therapeutic group factors and group session outcomes (Sandano et al., 2014). The Therapeutic Factor Scale (Butler & Fuhrman, 1983), for example, examines the existence of therapeutic factors across group sessions. It is based on the work of Yalom (2005), a leading scholar in group psychotherapy. Important group therapeutic factors delineated in this model include catharsis, insight, interpersonal learning, and cohesion, all essential dimensions of group dynamics. Other scales for measuring group outcomes include the Group Sessions Rating Scale (Getter, Litt, Kadden, & Cooney, 1992), practical for assessing the use of various therapeutic interventions by group members and by facilitators of counseling and psychoeducational groups; the Individual Group Member Interpersonal Process Scale (Soldz, Budman, Davis, & Demby, 1993) for analyzing group interactions along 21 group process dimensions; and the Interpersonal Relations Checklist (Shadish, 1986), a 66-item self- or observer-related behavioral checklist that assesses group members' knowledge and skills in understanding emotions, thoughts, and behaviors.

A variety of comprehensive scales measure a range of group dynamic processes simultaneously. These include the Group Emotionality Rating System (GERS; Karterud & Foss, 1989), the Hill Interaction Matrix (HIM; Hill, 1977), the Member-Leader Scoring System (Mann, Gibbard, & Hartman, 1967), the Hostility/Support Scale (Beck, 1983), and the Systematic Multiple Level Observation of Groups Scale, better known as SYMLOG (Bales et al., 1979). The GERS is a coding system for group functioning based on the work of Bion (1961). GERS includes five rated group dimensions of emotionality: Fight, Flight, Dependency, Pairing, and Neutral. The GERS is a conceptually driven rating system with high reliability and validity, though its utility is questionable in deriving a detailed process analysis of one session when used alone. It has been recommended in combination with qualitative methods such as hermeneutics.

The HIM is a behavioral coding scheme that measures the therapeutic quality of exchanges among group members (Hill, 1965). The HIM comprises four process instruments, including the HIM-SS (statement by statement), HIM-A and B (predicting an individual's behavior in a group), and HIM-G (examining group interaction). Another group dynamics assessment package, the Member-Leader Scoring System (Mann et al., 1967), is used to code the verbal interactions of group leaders and members in small groups. It has been used to understand the leader-to-member and member-to-leader exchanges in therapy, educational, and training groups (Cytrynbaum & Hallberg, 1993). The main focus of this group process system is on how group members relate to authority.

The Hostility/Support Scale (Beck, 1983) is a group process analysis measure designed to assess whether statements made in the course of group interaction are negative or supportive toward the person being addressed. The instrument was developed to identify changes from group periods of tension, criticism, and conflict to ones of mutual support and encouragement in psychotherapy groups. In conjunction with the Hostility/Support Scale, the Client and Therapist Experiencing Scales (Klein, Mathieu-Coughlan, & Kiesler, 1986) measure both therapist and group member exchanges, including engagement with and involvement in the group process and facilitative responses made by group therapists toward group members. Another group dynamics assessment system is SYMLOG, a measurement method for assessing norms, roles, and other dimensions of the group as a whole (Bales, 1980; Bales et al., 1979). It enables group workers to produce a three-dimensional graphical representation of data that are self-reported by members or provided by observers. For a more comprehensive discussion of methods to measure group dynamics, see Forsyth (2014), Schwartz and colleagues (2010), or Toseland and Rivas (2017).

CONCLUSION

In this chapter, I have presented a conceptual framework to help guide, organize, and refine thinking about group dynamics in social work practice with treatment and task groups. I have conceptualized these dynamics as falling into five domains: (1) communication processes and interaction patterns, (2) interpersonal attraction and cohesion, (3) social integration and influence, (4) power and control, and (5) the overall group culture.

Although an understanding of group dynamics is essential for effective practice with individuals and communities, it is my belief that focused attention to the dynamic processes that occur in groups is what distinguishes group work from other forms of social work practice. In the case of treatment groups, it is also important to remain cognizant that group work is not just working with a collection of individuals within a group context.

I hope that this chapter has highlighted the power that group dynamics have to change the lives of people. Neglecting the therapeutic power of group dynamics greatly diminishes the ability of the worker to help members achieve their goals. Similarly, task groups, such as committees, teams, and boards of directors, are not merely collections of individuals. The synergy that is created when people come together to work in these groups transcends the collection of individual efforts. The group takes on a life of its own, and the group dynamic processes that result have an impact far beyond what the collection of individuals working alone could accomplish by themselves.

Looking to the future, I believe that more attention will be paid to group dynamics in distance groups. It is becoming easier and less costly for people to meet over the telephone using teleconferencing capabilities and through videoconferencing, chat rooms, bulletin boards, and other forms of computer-mediated groups. (See Fitch, Chapter 33, this volume, for detailed information on this subject.) Because there are no visual cues in many distance groups and some use asynchronous communication, group dynamics are different in these groups than in face-to-face groups. Although some work has already been done to elucidate the dynamic processes in distance groups, more work is needed as these groups continue to become more popular in our culture (see, e.g., Page, 2010; Toseland & Rivas, 2017).

It is clear that culture, ethnicity, and race affect the dynamic processes that develop and evolve in groups. In this increasingly multicultural society, it is imperative to examine

in greater depth the impact of culture, ethnicity, and race on the groups in which we all participate. This priority is in keeping with a long and rich tradition within social work group practice of bringing together and fostering understanding and mutual respect among people from different backgrounds.

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CHAPTER 2

An Ecological/Systems/Seven C's Perspective on Group Practice

JOHN E. TROPMAN

This chapter considers the issues of ecological influence on groups and group practice. For these purposes, all kinds of groups might be considered, from therapeutic groups to performing groups to teams, among others (Andrews, 2001; Forte, 1994; Garvin, 1997; Tolman & Molidor, 1994).

AN ECOLOGICAL PERSPECTIVE

An ecological perspective uses group-in-context as a central lens. This perspective involves three sets of variables: the group, the context, and the interactions between the group and its components and the context and its components. This perspective uses seven group features to look at a group ecosystem. In particular, we consider:

- Group characteristics
- Group collaborations
- Group crucibles
- Group competencies
- Group conditions
- Group change
- Group context

Originally a biological term, the *ecological perspective* considers the relationship between a species and its environment. In a seashore ecosystem, for example, one might look at the crab population in question, the relevant contexts for that population, what it affects, and what affects it. More specifically, a social–ecological perspective in social work takes into account the interdependencies of a client or client system and other social systems

in its environment. An *ecology of groups* considers the influences that *extragroup* variables have on group activity, as well as the influences that group activity might have on those variables.

Structural Influence

Some extragroup influences are structural. These can involve such elements as formal, legal, organizational, demographic, or other pressures on group membership, mission and purpose, activities, resources, location, meeting times, and so on. Intraorganizational pressures on groups occur when organization-wide policies affect the networks of other organizations. Extra-organizational pressures affect freestanding groups as well as groups within organizations. Groups may also influence their environments by changing policy agendas, advocating for change, and uncovering previously unacknowledged vulnerable populations. For example, Unchained at Last—a relatively new organization formed to help women trapped in arranged marriages—has recently achieved national attention and raised awareness of this problem.¹

Cultural Influence

Other influences are cultural in nature and deal with the impact of intraorganizational and extragroup beliefs and values on the (sub)culture of the group itself and the impact of group attitudes and values on the larger context. Groups within agencies are influenced by the values, beliefs, and norms of those agencies, but they also influence the culture of those agencies. For example, if an agency group is a strong advocate for evidence-based practice, then the entire agency culture may move in that direction. Those same intra-agency groups may experience influence from other groups in the community, as well as from the culture of the community. These, too, are ecological influences.

A SYSTEMS PERSPECTIVE

A *systems perspective* looks at the overall group as a total entity acting and reacting in its organizational field. Although it is made up of individual members, the group is in reality a *sui generis* entity that has a history and an evolution greater than and different from those of its current members or participants. By “in reality,” I mean to emphasize that, although the group is in part the product of the elements that compose it and in part driven by the larger systems in which it nests (see Table 2.1), the group has a reality of its own that cannot be completely explained by its current composition or context. It has a history, a present, and a future. These realities of interaction and product can be productive or destructive, healthy or unhealthy. For example, in gangs, killing and vandalism may be the unhealthy product of group interaction, and group practitioners (gang workers) may be inserted into membership to change the nature of the interaction that leads to these unhealthy outcomes.

All systems—groups included, of course—typically contain processes of input, flow, exchange, transformation, and output over time.

- *Input* refers to influences such as resources, information, perspective, and energy that enter into or impinge on the group.
- *Flow* refers to the movement of these inputs through the system.

TABLE 2.1. Relationships among Six System Levels as Sources of Problems/Issues and Targets of Intervention

Source system level for problem/issue (independent variable)	“Target” system (dependent variable)					
	Individual	Group	Organization	Community	Society	World
Individual	<i>D</i> (1)	Usi(2)	Usi(3)	Usi(4)	Usi(5)	Usi(6)
Group	Dsi(7)	<i>D</i> (8)	Usi(9)	Usi(10)	Usi(11)	Usi(12)
Organization	Dsi(13)	Dsi (14)	<i>D</i> (15)	Usi(16)	Usi(17)	Usi(18)
Community	Dsi(19)	Dsi (20)	Dsi(21)	<i>D</i> (22)	Usi(23)	Usi(24)
Society	Dsi(25)	Dsi (26)	Dsi(27)	Dsi(28)	<i>D</i> (29)	Usi(30)
World	Dsi(31)	Dsi (32)	Dsi(33)	Dsi(34)	Dsi(35)	<i>D</i> (36)

Note. Target system, the system that is the target of change (effect); source system, the system that is the source of the impetus for change; *D*, direct system connection—that is, the target and source system are on the same level [*D*(1, 8, 15, 22, 29, and 36)], hence, a group problem or issue has a group-level intervention; Usi, upward system influence (compositional), where interventions through the components of a system level are used to change the system level; Dsi, downward system influence (contextual), where supraordinate systems influence their components; **Dsi**, downward influence on groups, the subject of this chapter [**Dsi** (14, 20, 26, and 32)].

- *Exchange* addresses the conversion of inputs from one form into another.
- *Transformation* addresses the changes to the inputs and their conversion within exchange.
- *Outputs* point to the discharges from the system (which are often the inputs to another system or systems, in linked fashion). Systems that deal with people are called *people processing systems*, and, if the goal is to change the people, we might call them *people-changing systems* (Street, Vinter, & Perrow, 1966).
- *Exchange* refers to the use of the previously mentioned influences to attain some system goal.
- *Transformation* addresses the change that resources and the system undergo as exchange takes place and calls attention to the product of the system. In people-processing systems, we call this *outcome* (a changed state).

Many agencies talk about *outputs* instead—number of group meetings held and number of times people attended the group, among other things. It is important to remember that outputs are a system measure rather than a result. In other words, if an agency has group meetings about anger management, its report that 14 sessions were held is an output. That number does not tell us anything about outcomes: Did the group members actually get better at anger management?

THE SEVEN C's PERSPECTIVE ON GROUP PRACTICE

As systems themselves embedded in an ecology of other, larger systems, groups have at least seven properties that group practitioners can use to describe and change them and on which system influences may have an impact, whether intentional or random. They are noted in the list presented earlier. Let us consider each.

Group Characteristics

Group characteristics involve variables such as group composition (gender, race, ethnicity, age, other memberships, etc.). Characteristics also involve temperament of groups and default styles for problem management and solution. Some groups, for example, are more task oriented and minimize process; others are more process oriented and have trouble getting to task. Some groups like to interact with participants outside the group; others value only the members.

Groups can also have cultural foci. *Clan* groups value loyalty and tribal identifications and commitment. *Hierarchical* groups focus on following directions and fidelity to task and/or process protocols. *Market-focused* groups look to results (and are, thus, something of an opposite of clan groups.) *Adhocratic* groups are more free-flowing and entrepreneurial. They are something of an opposite of hierarchical groups.²

Group practitioners may influence groups by adjusting, changing, or working with issues of composition. Practitioners are also encouraged to understand the culture/structure of the group they are working with, as noted earlier, because different group cultures have different operating codes and styles.

Group Collaborations

Groups exist within an ecological field of other groups. The larger ecological field is discussed in the *group context* section. *Group collaborations* are the smaller set of groups with which any particular group frequently works and on which it depends. They could be considered proximate groups in the ecological field. Groups that provide input (clients, cash, information) and receive outputs (referral destinations are typically within the *collaborations* set, but there may be other groups, such as technical experts and specialist groups).

In the “ecological field,” it is possible to divide collaborative groups using Amos Hawley’s distinction between categoric and corporate groups (Turner & Boyns, 2006). Categoric groups are those in which *similarity* of membership is identical—women’s groups, realtors’ groups, and so forth. Goals pursued here are for the benefit, usually, of the membership. Corporate groups are those in which *differentiation* is the key. Different kinds of members work together in the pursuit of an external goal.³ Groups we work with can be one or the other, and different approaches would be required in each and in the relationships of each to their ecological fields. The fact, for example, that we are members of so many groups creates the potential for and actuality of conflict between and among groups—one kind of ecological influence.

Practitioners should be aware of the nature and robustness of collaborations of the groups with which they are working. Group collaboration structures may need to be changed or updated.

Group Crucibles

As noted, groups have histories—a before, a now, and a future. With respect to the past, two elements stand out as particularly important “crucibles” for group experience. The first is a transition point—a new chairperson, a new purpose, a turn of some sort that marks a difference going forward. The second is a signature group experience (bad or good, though the bad ones are the more powerful) that “imprints” them with certain attitudes or mind-sets passed down as new members join the group. Such an event could be an especially honorific

meeting (good) or an especially awful meeting (bad), and, of course, there are many others. Reactions to the event enter the group subculture, continue to dominate group thinking and acting long after the precipitating occasion, and are operative even though circumstances have changed.

It is important in working with groups to assess whether there are any historical episodes that drive certain portions of their group process and activity. New information can rarely penetrate old attitudes; hence, practitioners often have to work on deemotionalizing old attitudes before new perspectives can be introduced.

Group Competencies

Generally speaking, groups have *competencies*, knowledge plus skills, for dealing with certain kinds of issues, problems, and tasks. All groups do not have the same kinds of competencies. For example, a cancer support group may be excellent at dealing with cancer-related issues but not other kinds of issues. A string quartet may do well with Haydn but not Brahms. A football team may execute pass plays well but not have a good running game. Decision-making groups may do well with some kinds of decisions but not others. Group practitioners may need to teach members knowledge about the competency area or help them develop skills they do not have. Practitioners may assist members in moderating skills that the group overapplies. (Think of the proverb, “When you are a hammer, everything looks like a nail.”)⁴

Group Conditions

Conditions refer to issues of group structure and culture. *Structure* refers to the way in which the group is organized, both formally and informally (though informal structure comes close to culture). The group may have a formal structure, with officers and other appointed, assigned, or elected roles, or it may be more loosely structured, with rotating roles. Group leaders have various names, and these denote differences in their functioning and authority. *Chairperson* is one; *task force manager* is another; *project lead* is a third.

Issues of power and titles can often affect how the group functions. Some “softer” titles convey leadership without an authoritative component. *Facilitator* is one; *convener* another. Quaker groups have *clerks*. All groups have to address the authority problem in one way or another. By *authority problem* I mean an acceptance of the group authority as superordinate to each individual’s preference, except in cases of disagreement with moral principles. If a member encounters difficulty with the group authority’s moral principles, he or she must leave the group.

Group *culture* addresses the norms and values of how the group works. Norms are group behavioral guidelines. Values—ideas to which feeling is attached—are concepts the group holds as vital. For example, some groups encourage open participation, in which members or participants say what they think as they wish; in others, newer members (or older ones) may speak first; there may be other rules of participation. How a group handles criticism of members is another issue. Some cultures allow—indeed encourage—very direct criticism and challenge, whereas others prefer more muted disagreement.

Group values are also important. Most groups like members or participants to be committed to the same kinds of things. Groups are entitled to have their values, but they must also recognize diversity and respect the values of others—both group members who hold

different values and other groups that have different values. Group practitioners often work with the structure and culture of groups to assist the group in its functioning.

Group Change

Group change has several foci. One refers to the development of a group over time, as in the stages of group development identified by Tuckman (1965) as “forming, storming, norming, and performing” (cited in Schopler & Galinsky, 1995, p. 10). These stages occur over time in group development (macro change), as well as each time a group meets (micro change). Group workers are aware that groups can get stuck, as it were, in either the macro or the micro phase or both.

Group goals are another area in which change can occur. Groups can pick goals to pursue and achieve (both outcomes and outputs). They may be formalized in a strategic plan, or they may be less formal. In *production groups*, whose purpose is to create some result—such as a decision, a piece of music, or a meal—change occurs as information, musical ideas, or ingredients that move into the group at the input stage are transformed and come out of the group as a finished product. Inputs thus can change. *Manufacturing groups* may change suppliers. *Decision groups* may discard old information sources and secure new ones. *Therapeutic groups* may change problem foci.

In *throughput*, the inputs are combined and remade or assembled into a final output, such as a decision, a performance, or a meal. This example further illustrates the difference between outputs and outcomes. In this case, the output goal is the decision, the performance, or the meal. However, another goal for the outcome is to produce a *good* decision, a *good* performance, or a *good* meal. A more encompassing goal might be to have the good decision implemented, to have the audience enjoy the good performance, and to have the diners enjoy the good meal.

In point of fact, groups need to change or they can become irrelevant. Boards of directors are a case in point. Many trustee practices are ritualized and routinized to the point where they no longer do the job of guiding a group. The failure of Hull House in Chicago is, ultimately, the tale of a fossilized trustee group (“Chicago’s Hull House Closes,” 2012). Hull House became the famous “boiled frog.”⁵

To assist groups in achieving outputs and outcomes, group practitioners may alter change processes (velocity, sequence, handling, etc.) to create different outputs or outcomes. For example, processes of becoming a group member may take too long and need to be shortened; alternatively, termination or processes of “unbecoming” a group member may take too long. Each of these issues might be addressed by a group practitioner.

Another feature of group change that needs to be considered is that elements of the group may not change at the same rate. Group structure may change, but old values remain. This is cultural lag, or what might be called “the ghost in the machine” (Kantor, 1989; Koestler, 1978).⁶ At other times, culture moves forward and old structure remains in place. Thus a case of structural lag exists.

Group Context

Groups exist, and are embedded in, contexts or milieus. This is the larger portion of the ecological field. At least four types of contexts are important: other groups, organizational contexts, community contexts, and societal contexts. Of course, there are world contexts for some groups, but I touch only briefly on this broadest context. Each of these entities,

systems in themselves, is part of an ecology that shapes and steers groups in ways that the group does not always understand or appreciate. It is also a set of groups that any particular group may seek to influence, by itself or in collaboration with other groups. This focus is the core of the chapter.

AN ECOLOGICAL/SYSTEMS PERSPECTIVE FOR GROUP PRACTICE

As a way of approaching the issue of group ecology and assisting us as we focus on this system model, we consider the following six levels: person, group (our focus here), organization, community, society, and world. Each system level or client system has two elements: the source of problems or issues and the target of intervention. That is, problems can occur at the individual, group, organization, community, society, or world levels. Each problem or issue may be dealt with at a variety of levels, or at several at once.

Direct intervention addresses the problem at the level at which it manifests (e.g., individual-level problems are addressed at the individual level). But that is not the only choice, as Table 2.1 makes clear. *Compositional* intervention looks “below” the system levels at which the problem occurs and seeks to change subsystem components. When a problem occurs at the group level, group practitioners may seek to intervene at the individual level. When a problem occurs in an organization, practitioners may wish to intervene at the group or individual level, and so on.

Some examples may help to clarify. If an individual has a problem or issue and the practitioner intervenes at the level of individual adjustment and change, the practitioner chooses a direct strategy. So, if an individual is depressed and is individually treated, that would be a direct strategy. If that individual joins a group with others who have similar issues, that would be downward system influence (cell 7). If a problem exists at a group level (e.g., “Queen Bee” junior high girls abusing “Wannabe” other girls in the school), then working with both groups directly would be a direct intervention (cell 8). An attempt to change policies in the school and to increase acceptance of diversity would be an organizational intervention (cell 14). An attempt to change culture in the community of the school, to involve parents, and so forth, would be a community intervention (cell 20).

Alternatively, *contextual* strategies are also appropriate (Tropman & Richards-Schuster, 2000). Here, the group practitioner might focus on systems that encompass the target system. Hence, if a problem occurs at the group level, the practitioner may wish to work at the organizational, community, societal, or world level in which the group is embedded. Ecologically speaking, contextual and compositional forces are the foci of this chapter. What might be the influences of organizational location, community location, societal location, or world location on the group and group practice in question?

Table 2.2 gives a completely described set of the intersections at which influence can occur. Each of the superordinate systems can influence both the group and group practice. Groups exist—and group practice occurs—in organizational, community, societal, and world contexts. Each context may influence groups and group practice, and groups and group practice may experience influence from one or all of those systems.

Obviously, every influence “cell” cannot be considered here—there are 36 of them, not counting, of course, the possibility of multiple influences just mentioned. But readers can see the flow and add examples themselves as well. The sheer size and complexity of the ecology, however, explains why workers might be tempted to give little more than lip service to the ecological perspective. There is a lot to think about. For our purposes here, we can see that

TABLE 2.2. Illustrative Grid of the Influence of “Suprasystem” Structure and Culture on Group Variables and Practice

	Group characteristics	Group crucibles	Group collaboration	Group competencies	Group conditions	Group change	Group context
Organizational	1	2	3	4	5	6	7
Community	8	9	10	11	12	13	14
Societal	15	16	17	18	19	20	21
World	22	23	24	25	26	27	28

each system level “above” the group has a structure and a culture (or really many structures and cultures). These structures and cultures can and do influence some of the C’s discussed earlier (group characteristics, group competencies, group conditions, group change, and group context). They can also influence the things that the group practitioner needs.

But as a start, let’s look at cells 1, 2, 3, 4, and 5 in Table 2.2. For example, in cell 1, an agency (organizational context for a group) might influence whom the group values as a member (e.g., domestic violence victims but not domestic violence perpetrators), and it might actually restrict membership as well. In cell 2, agency policy and practice influence what skills the group teaches group participants (e.g., fight vs. flight skills for victims). In cell 3, the agency also influences elements of group structure (when the group can meet, how often) and group culture (appropriate norms and values). In cell 5, agency conditions (culture and structure) can impact what the group may or may not be able to accomplish. Cell 4 represents the influence of an agency on forming and disbanding the group. The group, of course, reciprocally influences these things as well. Similar examples of influence come from the community, society, and world.

The concept of *influence* is not all of a piece, either. Let us assume that contextual influences fall into two large categories: structural and cultural forces. In other words, context can influence groups and group practice through values and beliefs (and other “soft” controls) or through rules, regulations, and other physical structures (and other “hard” controls). Either or both can operate to influence groups themselves, as well as group practice.

As mentioned before, structural elements are the hard side of society—laws, regulations, money, equipment, population, workers, members, and so forth. In general, these are the things that Karl Marx and B. F. Skinner (Cowling, 1999; Nye, 1996) felt to be dominant. On the other hand, the soft side of systems—cultures and subcultures—deals with attitudes, norms, beliefs, and values, which are harder to see and track. In general, these are the kinds of variables that Max Weber and Sigmund Freud (Nye, 1996; Tropman, 2002; Weber, 1956) thought mattered.

THE FLOW OF INFLUENCE

Each of the seven C’s can be an opportunity for influence for groups and a source of impact on groups. They also provide guides and areas for practitioners in the development of their own competencies.

Group Characteristics

Groups are limited by the people they can attract as members and participants. This influence obtains both in terms of numbers and types of people. Apart from “raw” numbers, ecological influences create openings for and barriers to group membership. Years ago, for example, when Boy Scout troops were primarily organized within a church/synagogue framework, the troops favored membership of those from their own faith and suggested that potential members from other faiths join their own faith-centered groups.

Communities influence groups through racial, ethnic, and religious segregation (usually housing based) and accepted prejudicial norms and values. Communities also exist within regions that vary greatly in size and diversity. In the United States, there are the New England or Yankee community, the somewhat broader Eastern community, the Midwestern community, the Southern (and perhaps Southwestern) community, the West, and, of course, the Far West, including California, Oregon, and Washington. This Far West community includes Vancouver, which sees itself more connected to the Pacific Rim than to Canada.

Each of these regions has structures and values that can sometimes lie dormant for years, appearing suddenly and unexpectedly on certain occasions, like a giant Internet pop-up advertisement. These structures and values influence group characteristics (not only in the Boy Scouts but also in all kinds of groups, including boards of directors, self-help groups, camping groups, character-building groups, and therapeutic groups, to name only a few).

Looking at societal influences, the “macro values” of a region certainly influence group participation. American society, for example, is well known for its participative, voluntaristic orientation, something that makes voluntary organizations more a part of the American landscape than is true elsewhere in the world (de Tocqueville, 1835/1945). On the other hand, there is evidence that this participative trend is declining. Harvard political scientist Robert Putnam, in his book *Bowling Alone* (2000), has pointed out that in many sectors volunteer participation in community groups is declining.

But perhaps this trend is not so surprising after all. For, on the one hand, America is known for its volunteerism; on the other, it is also known for its individualism. Culture in America celebrates the mountain man much more than the wagon train. And even in social work itself, group work has had a harder time than social casework, which focuses more on the individual. Moreover, there are world elements that affect group membership and characteristics. Some world elements are specific, such as groups that support international adoptions; others are more general, such as groups that are active on immigration and social justice issues.

For all of its problems, the United States seems to be the place to which people around the world want to come. It is both a testimony to that observation and a profound sorrow that people are literally dying to get to America. But the number of ethnicities and religions in the United States is staggering. Group practice needs not only to be aware of these trends and situations but also to develop the cultural competence to work with the greatest diversity of group members.

For practitioners, awareness of strengths and limitations of group characteristics—diversity is one outstanding example—may well be a focus for exploration and work.

Group Crucibles

Group practitioners need to be aware of transition imprinting and event imprinting, as discussed earlier, which may interfere with effective group function. Groups (and individuals)

can have both information and attitude problems. Crucibles are in the attitude problem category. Attitude problems need to be worked through first, because information does not pass easily through attitudinal barriers.

Group members, often in a retreat or other reflective event, can also look at their sub-culture and explore the “heuristics,” as Kahneman (2011) would say, that may have developed over time.

Group Collaborations

Groups can collaborate with other groups around a range of issues. Groups led by therapists may collaborate with or meet and exchange with other therapy groups. Groups of executives may do the same. Some of the collaborations may involve specific client subgroups; others may involve training and personal development activities.

Boards of directors may connect with other boards on programmatic or developmental activities as well. Practitioners may well need to explore the collaborations that groups have developed (or more likely the lack of them) and refresh. Additionally, practitioners may wish to invite the group to add collaborative activities.

Group Competencies

Competency, as noted, can be defined as knowledge plus skill. It includes both raw and synthesized knowledge, as well as the ability to reorganize and apply that knowledge to group task and process issues. Groups and individuals seem to do best when they are at the intersection of challenge and skill, as suggested in by Csikszentmihalyi (1990, p. 74) in a flow chart built into a graph. In this graph, the vertical axis shows the level of challenge confronting a person or group, while the horizontal axis shows the person's or group's skill level. As Csikszentmihalyi's flow chart illustrates, when a group's challenge exceeds its skill, the group becomes anxious and frenetic; when a group's skill exceeds its challenge, the group becomes bored. When challenge and skill are in harmony, groups are in the flow channel and performing well. Group practitioners need, overall, to work at increasing both the challenges and the skills (competencies) of groups, because neither groups nor individuals remain static. They are either *moving up* the flow channel or to one or the other side. Most typical is that skills increase faster than challenges, thus leading to group and member boredom (Csikszentmihalyi, 1990). Csikszentmihalyi's work connects nicely with that of Dreyfus and Dreyfus (1988). For them, moving up involves ascending a “staircase” of competence. The staircase moves from the novice to the beginner to the journeyperson to the expert to the master.

1. *Novice*: Simply stated, the novice is one who is just beginning and paying a lot of attention to rules. Performance is slow and jerky.
2. *Beginner*: The beginner is one who has learned the basics and is not attending to patterns not mentioned in rules. At the end of the beginner phase, *rule fade* begins—that situation in which we begin to operate more automatically. Performance is quicker and smoother.
3. *Journeyperson*: The journeyperson is one for whom rule fade has become mostly complete and performance is standard in terms of speed and smoothness.
4. *Expert*: The expert is one who knows many of the nuances and special features. Performance is rapid and sure.

5. *Master*: The master is one whose performance seems effortless and unerring, as well as innovative and creative.
6. *Maestro*: I have added a sixth level. At the maestro level, the job actually changes, and the individual or group moves beyond individual performance considerations to “orchestrate” other individuals and groups. As an example: Active during the Pittsburgh renaissance was a group called the Allegheny Conference. Composed of top community leaders, it orchestrated numerous other groups in the city to make renewal happen—foundations, political groups, corporations, unions, and others.

Csikszentmihalyi's (1990) flow chart illustrates the progress from novice to maestro. For example, in terms of location in the flow channel, the novice could be at 2/2, perhaps, the beginner at 3/3, the journey person at 4/4, the expert at 6/6, and the master at 9/9.

These differences can, of course, be applied to members or participants of the group. Group practitioners have to work skillfully to integrate memberships of different levels of personal competency. These designations can be applied to the group itself. Indeed, groups, teams, and boards are rated along these lines. For example, teams with lots of individual experts and masters do not necessarily perform well as a unit.

Context influences and affects both challenge and skill. Challenge usually comes from context—though in its raw form, challenge can arrive in undifferentiated pulses of varying amounts. It therefore needs to be managed (organized, structured) so as to be sufficiently stimulating yet not overwhelming when the pulses are large and boosted when the pulses are low.

Context influences the supply of competence in groups in several ways. From an organizational perspective, teams that have a complement of experts and masters and that function well are desirable assignments, rewards in themselves for employees of the organization (Ancona, Kochan, Van Maanen, Scully, & Westney, 1999). However, since there are only so many experts, masters, and maestros, the organizational allocation of these resources is always an issue.⁷ Organizations also, conversely, may find the suggestions of “top teams” irritating and weird. Organizations in general tend to the pedestrian rather than the innovative, in spite of lots of talk about organizational innovation.

One of the hallmarks of the very competent group is that it may pursue the “road not taken,” which usually threatens existing procedures and patterns of influence in the organization. Similar perspectives prevail with respect to community, societal, and world influences. The very skills of the top team may cause these perspectives to be threatening to community, societal, or world interests.

Musical groups and sports teams do not necessarily have the same problems as organizational groups and teams. In both cases, their working interaction is episodic and time limited. Furthermore, there are fairly well accepted standards of performance. Oddly, then, it is easier for top-performing musical or sports groups to gain acceptance. Coaches and maestros may, in a way, be thought of as group practitioners, as well as subject-matter experts.

With respect to competency, the goal of the group practitioner is to blend different competency levels as needed to assist the group to grow in competency as a group over time and to integrate the performance of groups with very competent members (experts and masters) such that their performance can be greater than the sum of the parts—not, as is so often the case, less.

One final point about competency: A group has a real potential to perform many tasks better than an individual, if the group is run right (Hackman, 1990, pp. 479 ff).⁸

Although the subject-matter knowledge may differ across groups (are they working on an engineering problem, a therapeutic problem, a musical piece, or a pass play?), at some point in their work all groups use an identical mechanism: the meeting. Skills in effective meeting structure are essential for group practitioners and groups themselves. As readers know, the meeting is one area of American society (and the world, for that matter) that seems to have a universally problematic reputation. Group practitioners can help their groups through practicing and teaching excellent meeting management skills (Tropman, 2013).

Group Conditions

Groups must have an organizational structure and culture, and although they can exist independently (a book club, for example), they often exist within organizations or an organization-forming milieu. They must find some way to relate or connect to that milieu for their own survival and prosperity. And it is likely to be the case that the following proposition applies: Fissures and cleavages that separate and affect the organization, community, society, and world are likely to affect the groups within those entities. More particularly, I offer the following principles:

- *The principle of structural isomorphism.* The structure of the group will be optimized by the group to fit, or articulate, the structures of its important organizational, community, societal, and world connections. If the external environment is complex, then the structure of the group is likely to be complex, as well. Otherwise it will have difficulty dealing with the environment on which it depends.
- *The principle of substantive isomorphism.* The substantive nature of the group's organization will tend to match that of its environment. Hence, if the group needs resources from, say, the United Way, it will tend to have someone (or a subcommittee) effect that connection.
- *The principle of values.* In general, groups will move toward adopting the values held by those on whom they depend for resources. (*Resources* here can mean space to meet, cash for programs, members, staff, or simple permission to exist, among others.)⁹

Of course, it is not as simple as this. Some groups will take the opposite tack and become specifically counterstructural or countercultural, or they will seek other environmental locations in which their behaviors and values will be welcomed. The group practitioner here needs to be aware of "resource dependency" and assist the group in developing appropriate intragroup structures and values, within ethical limits, that will optimize its interactions with extragroup environments.

Group Change

Groups, like other forms of social organization, tend to avoid change. When change occurs, it is usually problematic. Some changes, such as those that occur in the forming, storming, norming, performing, and adjourning stages, are built into the group structure itself and seem to be natural elements in group development (Tuckman, 1965). For this kind of change, group practitioners need to assist groups in awareness of the cycle and the need

to move through it. To move through it, the group must not become stuck in one cycle or endlessly repeat the cycle each time the group convenes. Of course, this work is made more difficult because new members who are “off-cycle” are continually entering the group.

Another kind of change is suggested by the description of flow in the Csikszentmihalyi (1990) figure mentioned earlier. As I noted, groups are in a dynamic, not a static, field, a point Csikszentmihalyi stresses. Being “in the flow channel” requires that the group continually undertake more complex tasks—that they move up the staircase of competence, as it were. The dynamism of the developmental situation means that groups cannot stand still. They either move up the flow channel or move into anxiety or boredom.

Thus the values and structures of any group need, at minimum, small adjustments over time. If done proactively, these adjustments (transactional change or evolution) allow the group to remain current and “ahead of the curve.” The general rule is that the environment (mentioned in the previous section) is slowly changing all the time. For groups, and other social entities, the rate of change within the group should be slightly greater than the rate of change in the environment, or the group may begin, slowly, to die. (This is the “boiled frog” effect, or the “just noticeable difference syndrome,” mentioned earlier; see footnote 5.)

But slow changes are not always the answer. Sometimes social groups need to make fundamental shifts in their purpose and mission. We call this kind of change *transformational* change or revolution (Tichy & Devanna, 1986). It may be a board changing the purpose of the agency, a string quartet taking on a whole new repertoire, a therapeutic group altering its fundamental focus, or other changes. These are among the most difficult changes to make, and groups often do not negotiate them successfully.

One particular kind of transformational change that is very common and very difficult deserves mention here. It is the transition from *group* to *organization*. I think it is fair to say that most social agencies started as small groups of concerned volunteers. For a while, they operated as a group, then they became a *quasi-organization* with a small/limited budget and a working board (usually the founders, who have renamed themselves as a board and gotten a few more friends to help).

At some point, however, the quasi-organization needs to move into formal organizational status. It often gets grants, a budget, and a professional executive. It is at this point that the camaraderie of the founding period seems to disappear. Founding group members are often “fired” from the organization (Flamholtz & Randle, 2000). Transformational change does mean that different members win and lose. Often, though, groups are not able to take this step; they remain in a sort of perpetual adolescence, with a problematic blend of informal funding structures and more formal group structures.

The role of the group practitioner here is to work with the group as a whole and with the individual members to assist in appropriate transitions. Often that means that founders must move on. But, like dictators, they often resist.¹⁰

Group Context

The “flow” approach—and indeed my approach in this chapter—suggests that context influences groups, and no one would seriously disagree. I discussed the influence of context above, but it is important to note that groups influence context as well. A touching article about a hospitalized terminally ill child in a family group reveals that “Hannah” would not let a large team of residents examine her. Rather, they had to come in smaller groups of two or, at the most, three. Also, they had to tell the 3-year-old Hannah their “real” names—Dr. Tony was the first. Soon all the doctors knew Hannah’s routine and abided by it. Shortly

after that, they applied her precepts to all their work with children, with great success. Though Hannah died, her “upward influence” affected her context (and a medical context at that) in a powerful and helpful way (Housden, 2002).

CONCLUSION

Obviously, contextual influences are many and varied. The purpose of this discussion is one of sensitization and awareness enhancement. There is a system in which groups exist that has elements of flow, exchange, and transformation. We can look as well at the way that the seven C's—characteristics, collaborations, crucibles, competencies, conditions, change, and context—affect group structure and culture. It needs to be understood as well—and group practitioners know this intuitively—that structure and culture, which need to support each other, do not change at the same rate and hence are separate foci of group practice efforts.

An ecological approach to group practice tries to be somewhat more specific about context, which is, after all, rather large. I have outlined here a “periodic table” of sorts, which at least specifies the structure of influence. Group practitioners can use it as a sort of checklist when they are working with groups to get a more detailed perspective on the kinds of influences that an ecological perspective might provide. All too often the ecological perspective is used as a synonym for “everything and anything out there” that might “be important.” The purpose of this work is to provide greater specification.

NOTES

1. Unchained at Last. (2015). Retrieved May 18, 2015, from www.unchainedatlast.org/news.
2. The Competing Values Framework was originally developed for organizations by Robert Quinn. For an excellent summary and evaluation, see Yu and Wu (2009).
3. The distinction is not crisp or exclusive. An orchestra could be thought of as all musicians, *categoric*, or a group of many different instruments, *corporate*. A musical performance may be for the benefit of others but also for the benefit of the musicians.
4. Typically, one teaches skills to individual members. Conceptually, though, it is possible to teach the group a skill, especially when the group needs to perform *qua* group, as in a sports team or musical ensemble.
5. This organizational fable posits that, if one puts a frog in cold water and slowly heats it to boiling, the frog will boil to death because it does not notice that its environment is changing. Group change is inhibited when change outside is slow and the “just noticeable difference” is small but continuing.
6. Originally coined by Oxford University philosopher Gilbert Ryle, this phrase is also the title of a book by Arthur Koestler and is also discussed by Rosabeth Kantor in the *Harvard Business Review*.
7. It is also worth noting that organizations are frequently bad at identifying the experts they do have and often misidentify “compliance” as “expertise.”
8. Hackman (1990) identifies several different types of work groups, among them top management groups, one-shot project groups, professional support groups, performing groups, human service groups (taking care of people), customer service groups, and production groups.
9. Similarly, Conant and Ashby (1970) offer the “Law of Requisite Variety,” which states that organizations (we could say groups) should be as “messy” as the surrounding environment.
10. For a good discussion, see www.how-matters.org/2013/03/24/founders-syndrome-part-i.

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CHAPTER 3

Social Group Work in a Global Context

REBECCA SMITH
JUSTIN BUCCHIO
BARBARA F. TURNAGE

The purpose of this chapter is to identify the international component and global issues in social group work and to raise the question, Is social group work socially constructed? If so, are there any global commonalities? Is it possible to have an international conception of social group work? Thus historical developments in social group work are briefly reviewed, the importance of the cultural context is discussed, and findings from reviews of the literature are presented. The chapter further reports findings from an international study of group work in social work education. The results of this study are discussed in the context of professional imperialism, international knowledge transfer, and electronic communication.

INTERNATIONAL INFLUENCES IN THE DEVELOPMENT OF SOCIAL GROUP WORK

Social group work, as we know it today, had its origins in international influences and exchanges. Canon Samuel Barnett founded the first settlement house based on principles of community, participation, and democracy at Toynbee Hall in London, England, in 1885. That same year, the first transatlantic visitor, a theological student from the United States, arrived, followed by many, including Jane Addams, who first visited in 1887. Visits were reciprocated, and Henrietta Barnett, wife of Canon Barnett, was appointed president of the United States Federation of University Settlements in 1920 (Reinders, 1982). It is ironic that, despite the inconvenience and expense of travel and communication at the time, there was much more interaction and mutual transatlantic influence in those early days, maybe even more than at the present time. The settlement movement grew out of the dire social conditions created by industrialization, and, in contrast to the Charity Organization Society, it was identified with a social rather than an individual response to those conditions, thus

providing a beginning for the development of group work. The settlement house movement, on the one hand, leaned toward social reform and, on the other, utilized the power of the group to provide education, training, and skills of daily living directed toward emancipation of the poor (in England) and new undereducated immigrants (in the United States). This emphasis on social reform and human empowerment changed in the second decade of the 20th century, when the emphasis moved toward recreational and service programs, with an activity orientation geared to serve the troops returning from World War I. Later, the second wave of international influence on group work saw the impact of psychoanalysis from Europe, and social group work extended itself to incorporate group treatment and therapy in its already extensive *modus operandi* (Coyle, 1948; Konopka, 1949; Shaffer & Galinsky, 1989). This development was reinforced by the mental health needs of soldiers in Britain and the United States returning from World War II and the limited resources for treatment. New models of group work emerged in psychiatry and influenced social group work to become treatment oriented (Bion, 1961; Foulkes & Anthony, 1957). Refugees from Europe challenged by the rise of National Socialism, such as Gisela Konopka and Fritz Redl, made seminal contributions to the development of group work with children and adolescents. Thus the early history of social group work reflects two strands of development: (1) activity-, recreation-, and education-oriented groups, reflected in the work of the settlement houses and organizations such as the YMCA, and (2) the mental health and treatment focus coming from the medical/psychiatric service delivery sector.

A GLOBAL PERSPECTIVE ON SOCIAL GROUP WORK TODAY

In seeking a global context for social group work, one has but to take cognizance of the single common thread that binds all humankind, the gregarious nature of the human race, which, from the very inception of the species, has led humans to organize themselves in groups and collectivities. This tendency in humans to gravitate toward living, functioning, and interacting in groups, from dyads to clans, reinforces the concept of groups as the natural and desirable habitat of humankind. If groups serve as the cradle of social strength, human growth, and development, then it stands to reason that groups must provide some gains to humans. To understand what these gains are, attributes of groups—such as roles, functions, structure, and process—have been identified, examined, and utilized in an organized and systematic way to maximize human well-being and, in turn, the well-being of the society in which they live. That all people interact and function in and through groups in a given society is a universally recognized condition; that these interactions may differ from one region to another is determined by the cultural context of the interaction (Marrs Fuchsel, 2014; Okum, Fried, & Okum, 1999) and requires the recognition and understanding of the role of culture on the group work model (Au et al., 2010; Chan & O’Conner, 2008).

This contextual difference has been researched by North American proponents of social group work and has focused on the various processes associated with group activities, group phases and development, structure, and goals (Cartwright & Zander, 1968; Forsyth, 1999). The applied science/art of social work has utilized and adapted these findings to develop both professional interventions and methods of social group work in work with task, process, and educational groups (Coyle, 1959; Forsythe, 1999; Garvin, 1997; Hartford, 1972; Northen, 1988; Vinter, 1967; Wilson & Ryland, 1949). The question arises, Are these structures, processes, functions, roles, and skills—identified by this substantial body of North American social work literature—equally evident and recognizable in other countries?

Group work in Western industrialized countries has typically comprised small group interventions that are found in task and process groups. In many countries of the global south (i.e., less industrialized and less technologically advanced countries), group work takes on different ideologies that relate to larger systems and that may be more politically radical, such as conscientization and liberation theology, which have influenced practice in South America (Freire, 1973). Social development incorporates economic and social factors in the attempt to empower constituencies and communities to participate in decision making with the goal of structural change (Elliott & Mayadas, 1996; Estes, 1992; Mayadas & Elliott, 1995; Midgley, 1995). Other forms of social group work are age-old and have evolved naturally, many based on the ideology of internal political self-governance within the context of a country's central government, such as the village level local council in India (*panchayats*). Other ideologies that use basic group work strategies and that are applied globally use basic group work strategies to promote community organization and development (Regan & Lee, 1992). With so many worldwide applications of social group work, the question of whether social group work is a socially constructed concept of the Western world often surfaces.

CULTURAL CONTEXT AND GROUP WORK

Can one surmise that there is a culture-specific orientation to groups held by respective societies around the world? This stance might best be determined by viewing the relationships of individuals to groups, and vice versa, on a continuum, at one extreme of which the locus of social control lies with the person, whereas at the other extreme, the group is regarded as the unit of social control.

A doctrine of individualism suggests that the cultural milieu in societies tends to attribute primary significance to the individual vis-à-vis the group. Individuals function within the context of the group but maintain their social identities (Forsyth, 1999). The individuation of the person supersedes the power of the group identity. Groups within this orientation are entities designed to enhance individual well-being. For example, in the North American and European tradition, the methodology and interventions of social group work are specifically designed for the betterment of the individual, whether the goal is therapeutic change, social enhancement, interpersonal competence, skill acquisition, or self-help and support (Edwards & Edwards, 1984; Roy, Pullen-Sansfaçon, Doucet, & Rochette, 2013). Similarly, task and decision-making groups are designed to increase organizational efficiency through concerted group effort to improve service delivery to clients, customers, and patrons (Cohen & Olshever, 2013). Groups in individual cultures serve as instruments of change for human well-being. Individual-oriented cultures are, by and large, associated with Western industrialized and technologically advanced nations, in which the competitive philosophy of self-enhancement has already disintegrated the bonding of natural groups (extended families, close communities, and agrarian households in which individuals, of necessity, had depended on the group for survival). With the decrease in dependency on the natural group, the need for groups as an integral part of the human environment has become only more evident and has taken the shape of professional services through the medium of planned group interventions. Because groups are acknowledged as a medium of change in individualistic societies, the role of the group worker, at any level of task or process groups, remains overt, clearly delineated, mutually acknowledged, and directly focused on the techniques and knowledge that are recognized as the expertise needed to achieve the desired outcome. This lack of role ambiguity and presence of task clarity leads to brevity of



FIGURE 3.1. Locus of social control.

time expended on the task and results in relatively uncomplicated and open communication patterns, attributes of social interaction that are valued by the individual-oriented society.

The group-oriented society, on the other hand, focuses on the group's maintaining social control through the group ego, to which individuals surrender their respective identities. Individual differences are minimized, if not ignored, and personal preferences, values, attributes, and characteristics are relegated to a *persona non grata* status (Chu & Sue, 1984). Assertion of individuality is seen as an act of sedition against the group, the ultimate price for which could be total ostracism. Thus, within cultures in which the group is sacrosanct and the individual merely a cog in the wheel, "outsiders" such as professional social workers are viewed with suspicion as interlopers and their presence regarded as an intrusion. Group-oriented cultures behave as closed systems with esoteric norms, traditions, rituals, and values that all members of the group must adhere to or lose face with the group (Sue & Sue, 1999). Most countries of the global south profess a group ego. Japan, even though technologically an advanced nation that bears greater resemblance to the global north in its material productivity, shares the concept of group ego with its more traditional neighbors. The group-oriented cultures primarily value the group; individuals are valued only to the extent to which they conform and abnegate their own interests in the overarching interest of the group.

On the surface, it would appear that in cultures in which the concept of group is so deeply imbedded and in which social control has been with the group since the beginning of history, the techniques of social group work would be easily incorporated and applied toward desired social and behavioral change. However, the experience of professional group workers has demonstrated otherwise (Okum et al., 1999; Pearson, 1991). The direct methods of interventions associated with social group work from its professional inception, practiced in individual-oriented low-context cultures, are questioned and rejected. Sharing personal concerns with strangers is seen as betrayal of the group. The integrity of the group requires "trust." Why should one place one's faith in strangers who advocate the "unnatural" formation of groups as decision makers and change agents when the community has, in its opinion, managed society for centuries through its own deeply embedded group structure (Lee, Juan, & Hom, 1984)? The universal practice of group work as it is understood in the global north, if applied to the global south, is fraught with difficulties and requires an inordinate amount of expended time. It may take a year, or perhaps more, for a high-context culture to allow the "strangers" to share their views and for the community to actually listen. This prolonged testing period, so alien to the service provider educated in the global north, frequently ends in frustration, failure, and a stalemate situation (Mistry & Brown, 1997).

Although no one culture would fall into the extreme on either end of the individual-group continuum, the natural proclivity of cultures to lean toward one or the other affects the nature of group work interventions if cultural disparity exists between clients and professionals. Put another way, successful group work interventions on a global level are shaped by and are contingent on how well these interventions dovetail with the cultural expectations of the country.

GROUP WORK AND INTERNATIONAL INFLUENCES

For professionals to cope with cultural variance, they need a global perspective to keep them sensitively alert to differences and aware of the repercussions of these differences on practice (Cohen & Olshever, 2013). From this recognition, a set of practice standards has been established to aid in the process of better understanding and incorporating cross-cultural considerations while serving various cultures through the use of social group work (Roy et al., 2013). Incorporating such standards into practice and having a global perspective could remove the cobwebs and dispel the mirage, showing us that, although the assumptions we hold regarding universal truth or ethical behavior or a problematic situation may indeed be justifiable for us, they may have very different connotations for other cultures. Moreover, service delivery systems in various parts of the world are differently designed and constructed according to their own perceived needs; hence methods of practice, to be effective, also need to match the existing service systems of a given culture.

Group work is significantly influenced by the contexts within which the social work profession operates and varies in countries across the world (Garvin, 1984). Such contextual influences are found in multiple entities, such as political and economic structures, social norms, and the systems in which services are delivered. For example, in countries in which social workers are mainly government or local government employees, such as the United Kingdom, the role of mandatory social work may play a larger part and transpire not only in the form of social control of certain populations, such as delinquents, but also in the statutory requirement of that government body to provide certain services for some populations, for example, home-based services.

Another illustration of the political influences on group work practice is shown by Brown (1990), who argues that group work is based on principles of shared responsibility, collective solutions to problems, mutual aid, and empowerment. As a consequence of the conservative trend in British politics during the administrations of Prime Ministers Margaret Thatcher and John Major, group work was polarized into social control and social action. Hence, during that period, group work with offenders, child abusers, substance abusers, and delinquents became more evident, while at the same time there was a reactive and opposite polarity of social action groups, in which members focused on goals external to the group at the expense of internal dynamics. Further examples of contextual differences that reflect political arrangements are found in the cooperative movement in Canada for profit sharing and distribution of everyday goods, as well as the kibbutz movement, a social experiment in group living in Israel. These examples also reflect the social construction of social group work (Shapiro, 1990).

Forte (1994) undertook a content analysis of the journal articles on group work from four countries: Israel, Great Britain, Canada, and Australia. In total in this study, 271 published articles represented 17 countries outside the United States. The rank order of countries in terms of productivity was Canada, Great Britain, Australia, and Israel. Family and clinical welfare settings represented 21% of the articles, with corrections (12%) and mental health (11%) preceding medical social work (6.6%) and geriatrics (6.3%). Most authors were social workers.

Regarding content of the international literature on social group work, Forte's (1994) study confirmed the findings of earlier analyses by Silverman (1966) and Feldman (1987) that the majority of articles (39.1% in the Forte [1994] study) were not research-based but were descriptions of practice with only elementary data analysis; 47.1% of the research articles used descriptive statistics, and a further 26.5% used only simple bivariate analysis.

Although it has been noted that further investigation needs to be conducted to produce both qualitative and quantitative data to contribute to the knowledge base of social group work practices (Forte, 1994), the available descriptive accounts of international group work provide a good picture of the state of the art. Literature shows that the international groups possess both similarities to and some differences from group work in the United States (Tolman, 1989). Similarities included weekly meetings, a preference for closed-ended groups, length of meetings, and a comparable number of sessions. Forte (1994) further noted that differences occurred in the theory base preferred by international group workers, who favored self-help, group psychotherapy, feminist theory, and social goals as theoretical models among a very broad range reported. International groups did not focus primarily on services to children. These groups focused on adults and the elderly, as well as adolescents. Leading areas of focus were problems with family, aging, and health. Forte points out that the range seemed broader than the range of American group work reported by Tolman (1989).

In summary, Forte reports that Australia published more research-based articles, that Canadian group work was based on more traditional theoretical roles, and that British group work represented newer models (e.g., Mullender & Ward, 1991). For Britain, Canada, Israel, and Australia, the major focus of group work was on adults.

Rice (1999) compared group work in the United States and Australia using surveys of students in 12 schools of social work and practitioners in 30 agencies in Australia and of 230 family and field coordinators in the United States. Models of group work practice reported were, in the same rank order for both countries: (1) education and psychoeducation, (2) therapeutic and personal growth-oriented groups, (3) problem-solving and task groups, and (4) skills training groups. Rice reports that there was a stronger emphasis on educational and psychoeducational groups in Australia, although the rank order in the two countries was the same.

CURRENT STATUS OF GROUP WORK ACROSS THE GLOBE: AN EMPIRICAL STUDY

Today there are numerous conceptualizations of social group work; however, if common principles were to be extrapolated from these bases and presented in one integrated framework, they would consist of a comprehensive understanding of group dynamics, a recognition of processes and interventions as they shape the group structure, a systemic perspective for the analysis of all social exchanges within the group, and, finally, a means of evaluation of group intervention outcome (Garvin, 1997; Schopler & Galinsky, 1995; Toseland & Rivas, 2001). These principles are employed in all orientations of social group work in the United States and Canada and in those parts of the globe where American social group work has been exported, but are they also prevalent in countries in which group work may have had a different origin? This research question prompted a survey of schools of social work across the globe to assess the current situation with regard to international social group work. A recent survey of social group work content in doctoral programs in the United States suggested that social group work has a low priority in the doctoral curricula of Canadian and U.S. schools of social work (Mayadas, Smith, & Elliott, 2001). Low availability of social group work courses and low enrollment in them, as well as low priority status ascribed to social group work, was evident in the majority of the responding programs. These findings raised concern that social work educators were not being prepared to teach group work. Yet, in the field of practice, social workers are consistently confronted with work in groups, such

as committees, task groups, peer groups, cliques, and coalitions. The focus on a study of group work in social work education as opposed to practice was based on the rationale that if group work was to have any place in social work practice in a particular country, then it must start with academic training and education of professionals. The assumptions of the researchers were that group-oriented cultures would place a greater curriculum emphasis on the study of task and support groups, whereas individual-oriented cultures would emphasize both but might lean more toward treatment groups.

This international study is a follow-up study of the North American survey to see whether the same factors existed internationally. Other, specific goals of the study are to explore whether social group work:

- Is included in the curricula of professional schools at the master's level
- Is ranked equally with other social work intervention methods in the curriculum
- Forms a major concentration of study in the program
- Has identifiable models of group work used in teaching
- Has specific teaching methods associated with its education and training

Methodology

A survey was sent to 443 schools in 32 countries that are listed as members of the International Association of Schools of Social Work. A Spanish version was sent to Spanish-speaking countries; the remainder were in English. Of these, 135 surveys (response rate 30.5%) were returned, representing schools from Africa, Asia, Australia, Europe, North America, and South America.

The survey instrument consisted of 30 items. Demographic data on the schools, the social work programs, and the social work faculty were obtained. Information on group work included courses offered in group work, group work content in other social work courses, the main focus of group work content, theoretical orientation, group work in the practicum, and group work as a component of thesis and/or dissertation.

Findings

Of the 135 schools responding to the survey, 37% were in Europe, 35.6% were in North America, 10.4% were in Asia, 6.7% were in Africa, 5.9% were in South America, and 4.4% were in Australia (see Table 3.1). The majority of the responding schools (82.6%) were in urban settings, with 12.1% being located in suburban areas and 5.3% in rural areas. Most of the responding social work programs were located in larger universities: 52.6% had enrollments of 8,000 students or more; 25.2% had enrollments between 1,000 and 8,000 students; and 14.8% had enrollments of fewer than 1,000 students.

These 135 institutions with social work programs represent 41,495 social work students and 2,497 social work faculty members, a 16:1 student-to-faculty ratio. Thirty percent of the institutions required a doctoral degree for teaching, 56% required the master's in social work (MSW), and 14% accepted other social science degrees. The requirement for a PhD was most prevalent in North America, whereas the MSW was most prevalent in Europe as the terminal degree for teaching.

The degrees awarded by the reporting institutions varied. Doctoral degrees were awarded by 38.5% of the schools, MSW degrees were awarded by 63.7%, bachelor's in social work (BSW) degrees were awarded by 61.5%, and 15.6% of the schools awarded

TABLE 3.1. Universities Responding to Survey

Location of responding schools	<i>n</i>	%
Africa	9	6.7
Asia	14	10.4
Australia	6	4.4
Europe	50	37.0
North America	48	35.6
South America	8	5.9
Total	135	100

other degrees or certificates in the field of social work. In reference to part-time social work programs, 29.6% of doctoral programs, 43.7% of MSW programs, 28.1% of BSW programs, and 11.9% of other social work education programs could be completed on a part-time basis. Australia reported the largest number of part-time programs in all categories.

The 135 responding schools reported that 174 social work faculty members were trained instructors and were teaching in group work courses. As noted previously, the total number of social work faculty members represented was 2,497. Therefore, only 7% of social work faculty in this study are group work specialists.

Of the 174 group work faculty members, 47.7% have more than 10 years of experience, 28.7% have 6–10 years of experience, 21.8% have 1–5 years of experience, and 17.2% have less than 1 year of experience (see Table 3.2). The correlation between faculty trained in group work and faculty experienced in group work is statistically significant ($p = .001$). Only 7% of faculty members are trained in group work, and the majority of these are long-time faculty members, indicating an expected decline in the number of trained group work faculty members as the more experienced retire.

Schools were asked to identify the main focus of the group work content in their courses. A compilation of study data resulted in a group work approach for each of the geographical areas relating to focus of content. Eight foci of group work content included therapy, support, self-development, education, research, administration, community practice, and social action. The schools were asked to prioritize group work content in their programs as high, low, or not a priority (see Table 3.3). The highest rankings were from South America and Africa, with 87.5% of schools listing a high priority. This was followed by Europe at 68.1%, North America at 53.0%, and Asia and Australia at 50.0%, with an overall ranking of group work as a high priority at 62.7%.

TABLE 3.2. Group Work Faculty Experience in Group Work Practice

Years of experience	<i>n</i>	%
0–1	3	17.2
1–5	38	21.8
6–10	50	28.7
10+	83	47.7

TABLE 3.3. Foci of Group Work Content, Rank Ordered by Continent

Rank order	Africa	Asia	Australia	Europe	North America	South America	Global model
1	Support	Self-dev.	Support	Support	Support	Comm. prac.	Support
2	Therapy	Support	Therapy	Self-dev.	Therapy	Soc. act.	Comm. prac.
3	Comm. prac.	Therapy	Educ.	Comm. prac.	Comm. prac.	Res.	Self-dev.
4	Self-dev.	Comm. prac.	Comm. prac.	Soc. act.	Educ.	Self-dev.	Therapy
5	Educ.	Educ.	Soc. act.	Educ.	Self-dev.	Educ.	Soc. act.
6	Res.	Soc. act.	Self-Dev	Therapy	Soc. act.	Support	Educ.
7	Soc. act.	Admin.	Res.	Admin.	Admin.	Admin.	Res.
8	Admin.	Res.	Admin.	Res.	Res.	Therapy	Admin.

Summary of Main Findings

The main findings of the study may be summarized as follows:

- Only 7% of social work faculty members in universities worldwide are considered to be social group work specialists.
- Of these social group work specialists, 36.5% list social group work as their *primary* area of expertise.
- Those who are identified as group work faculty are well experienced: 76.4% have more than 6 years of experience, with 47.7% having more than 10 years of experience.
- South America and Africa were foremost in listing group work courses as high priority.
- Global approaches to group work were, with the exception of South America, focused on those that seem to emphasize individual needs, such as support, therapy, and self-development.

Limitations of the Study

This study looks at the worldwide spread of social group work and attempts to investigate whether social group work has a common language and shared approaches to practice. Though the survey responses are subjective, they draw attention to possible trends and open up heuristic possibilities for more rigorous studies. For example, issues for further investigations would need to address ways of assessing comparability of course content.

A confounding trend in the survey is the consistency with which schools across the globe gave primary importance to support groups, with only Asian and South American schools leaning more toward self-development and community practice, respectively. This finding may be attributed to a limitation of the survey that may reflect cultural variance in interpretation.

A total of 7% of faculty members were experienced in and were identified as teachers of social group work, and 47.7% of these had more than 10 years of experience. These findings suggest that these individuals represent a small and older, because of years of experience, cohort of faculty and are consistent with findings in the North American study, as reported

earlier (Mayadas et al., 2001). The questions that arise from this study are: Are a sufficient number of new faculty members being trained in social group work? Are new faculty members being trained adequately, or are they being trained at all? If they are not being appropriately trained, yet students continue to practice social group work in their internships and practitioners conduct groups in practice, is social work education giving way to the apprenticeship/anecdotal model of group work training? This view might very well seem to be supported by the fact that the group work literature is dominated by anecdotal and descriptive accounts of practice.

Table 3.3 lists the rank order of group work approaches prevalent across continents. The striking similarity in approaches suggests a global linkage in the literature and academic and scholarly exchange. Most of the approaches are focused on the psychosocial approach, and it would be safe to say with Midgley (1981) that “professional imperialism” has spread American literature, values, ethics, and practice models across the globe through a predominantly one-way transfer of knowledge.

FUTURE TRENDS

What is the future of the international perspective in social group work? As in North America, it seems that there is an imperative for training. As demonstrated by the literature, there is an imperative for theory building and a move to build research on group work practice, as social work progresses to evidence-based practice. It would also be desirable to develop indigenous models in different parts of the world that depart from the established psychosocial model. Finally, the rapid growth in technology has opened new areas of practice for international social group work. An operational measure of internationalism is the existence of linkages or channels of communication between groups, organizations, and societies. The term *globalization* demonstrates these linkages through multilevel cross-national exchanges.

Social group work, which has historically been shaped by globalization, now finds a new dimension with virtual reality added to its international exchange repertoire. Web-based technology has been used to enhance social work group interactions and performance. Both synchronous and asynchronous delivery formats have been used (East, LaMendola, & Alter, 2014). For example, Web-based groups have been used in educational institutions when teaching via online and hybrid courses. These groups may have a particular date and time (synchronous) when each group member logs in to the group site. Group members may also login at different times (asynchronous) to perform the assigned task.

As in classroom settings, practitioners who use Web-based groups must provide feedback to the group overall and to the client individually (Coll, Rochera, & Gispert, 2014). In support groups, practitioners can use feedback to help clients develop desired skills, explain peer reactions and responses, and ask probing questions. As for students, both synchronous and asynchronous Web-based formats can be useful.

Experiences in the Web-based group environment can teach students and clients how to create a social presence via posting original items and then responding to peer postings. This social presence carries over into face-to-face interactions and expectations. Learning how to express their thoughts and feelings in writing provides the student and client an opportunity to socially present themselves (Coll et al., 2014). This is a new field that has great potential for international social group work practice and that is wide open for theory development and research.

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CHAPTER 4

An Empowerment Perspective

MARGOT BRETON

The word *empowerment* is ubiquitous, and it is given drastically different meanings. These meanings range from the extreme left, radical Marxist one—which postulates that the whole system must be overthrown before the people can be empowered—to the equally extreme right-wing, trickle-down-economics meaning—which assumes that if we give more to the rich and powerful, more will trickle down to the poor and powerless, who will then become empowered.

There is, however, agreement, in social work and related fields, that empowerment involves both a process and a goal whereby people gain mastery and control over their lives and become active participants in efforts to influence their environments (Rappaport, 1987).

The process in question is one of consciousness raising, or, more accurately, conscientization, in which people become aware of (1) the interconnections between issues and the ways in which personal issues are linked to interpersonal and to political, social, economic, and cultural issues and (2) how the interconnections between the personal and the political manifest themselves in specific power arrangements in the world around them. They go from a naïve consciousness of interconnections to a critical awareness of the workings of power (Freire, 1970/1993). The goal is to gain access to needed resources through collective action on the environment. It is important to stress that change at the personal–interpersonal level without change at the social–political level does not lead to empowerment (see Breton, 1994a; Carr, 2004; DuBois & Miley, 1999; Gutiérrez, 1994; Lee, 2001; Mullender, Ward, & Fleming, 2013).

The cognitive and psychological shift resulting from the process of conscientization is a *necessary* condition for people to move from being disempowered and having no control over what happens to them to being empowered—but it is not a *sufficient* condition. To become empowered, people must act on their cognitive and psychological discoveries, on how they have come to think and feel about themselves and their world, to try to change that

world (Freire, 1970/1993). “Without exercising the power to act, the awareness of personal strengths and competence may give people a *sense* of empowerment (Riger, 1993) and lead them to think and feel that they have more power and are more in control—it does not mean that they have more power and are more in control” (Breton, 2002, p. 26; see Bronstein & McPhee, 2009, on the difference between consciousness-raising and empowerment).

Lest the idea of empowerment be diluted into an “everything bucket” (Pernell, 1986, p. 13)—as when, for example, to become empowered is confused with to learn or to gain self-esteem—it is important to stress that empowerment is directly related to oppression (Sansfaçon, Ward, Robichaud, Dumais-Michaud, & Clegg, 2014; Ward & Mullender, 1991). The disempowered are individuals burdened with a stigmatized collective identity (Solomon, 1976).

This chapter begins by clarifying issues of purpose and of the means of attaining purpose in empowerment-oriented groups. It then analyzes the components of group practice from an empowerment perspective. Philosophical and conceptual foundations for this practice are examined next. The concluding section focuses on trends and future directions.

THE PURPOSE OF GROUP WORK FROM AN EMPOWERMENT PERSPECTIVE

In light of the meaning just given to empowerment, the overall purpose of groups, from an empowerment perspective, is to change oppressive cognitive, behavioral, social, and political structures or conditions that thwart the control people have over their lives, that prevent them from accessing needed resources, and that keep them from participating in the life of their community.

Cognitive structures are oppressive when people see themselves and the world in such a way that they automatically blame themselves for their situations. Fanon (1968), Memmi (1965), and Freire (1970/1993) discuss the phenomenon of the oppressed internalizing the opinions oppressors hold of them. Oppressive cognitive structures can also lead individuals to perceive their situations as inevitable, either the will of God or the result of destiny or fate. Thus individuals may fail to seek out or to effectively use social services, consequently being labeled by professionals as “unmotivated,” “resistant,” or “hard to reach” (see Breton, 1985; Holmes & Saleebey, 1993). Finally, oppressive cognitive structures may lead individuals to perceive their situations as hopeless and themselves as helpless. Seligman (1975) notes that as a result of “learned helplessness,” individuals believe that nothing they do will affect the outcome of events. Oppressive cognitive structures, whatever form they take, create oppressive behavioral structures (i.e., ways of thinking lead to ways of behaving). Individuals abdicate their competence—they do not make use of their strengths, skills, and abilities—and give up trying to influence their environment (Breton, 1994b).

Oppressive social structures, which include oppressive institutional and organizational structures, are the arrangements sanctioned by society and embodied in policies and procedures that exclude individuals from participating in the decisions that affect their lives and keep them from accessing the resources they need to have decent lives. Policies and procedures are the result of value orientations. Public policies that affect how society’s resources are distributed derive from the beliefs held by that society. When those beliefs are colored by racism, colonialism, sexism, ageism, and other discriminatory and exclusivist ideologies—such as a market-oriented philosophy that holds that governments should leave

social welfare and health matters to the market—the public policies that result will hurt all but the wealthy and powerful members of that society (see Haynes & Mickelson, 1997).

Organizational and professional policies and procedures are also affected by value orientations. The penchant for paternalism prevalent in social work (Reamer, 1983) has, among other things, influenced the hierarchical bureaucratic arrangements that characterize many social work organizations, tending to reduce the independence and professional autonomy of social workers. Similarly, valuing the medical paradigm at the expense of social change paradigms has led to the view of the professional as the expert who knows best what people need and, consequently, to discounting the opinions and wishes of people, to neglecting their strengths, and to overlooking their abilities to assess their situations and to make decisions regarding these situations (see Hartman, 1993; Holmes & Saleebey, 1993; Weick, 1983). It has also led to the ever-growing popularity of “clinical” practice and the relative inattention to social justice issues (see Jacobson & Rugeley, 2007; Specht & Courtney, 1994).

In democracies, oppressive political structures refer to institutions, policies, and practices that systematically exclude citizens from participating in the normal responsibilities and benefits of a free and open society. When, for example, voting arrangements are such that the poor or members of other marginalized groups are unable to exercise their electoral responsibility, those arrangements are oppressive. Practices and policies that deny the right of individuals and groups to participate in public protests and demonstrations or that make the exercise of that right onerous constitute other types of oppressive political structures. A recent study points to the existence of such structures within social work (Andrews & Reisch, 2002).

To change oppressive cognitive and behavioral structures, a combination of cognitive restructuring and behavioral unlearning and relearning is required. In empowerment-oriented groups, this means facilitating a consciousness-raising process aimed at surmounting internal blocks (negative self-evaluations) and at connecting personal and interpersonal situations to the socioeconomic context. This work must be accompanied by work at the behavioral level, that is, opportunities must be provided within the safety of the group for members to experience new ways of acting and interacting based on their new ways of perceiving themselves and their world.

To change social and political structures requires groups to mobilize and organize to take collective action. Action aimed at bringing about societal change (surmounting external blocks) will have a better chance of succeeding if groups do not have to “go it alone.” It therefore pays to create partnerships between empowerment-oriented groups and communities and to connect groups to community resources, thereby establishing support, as well as information networks. Establishing connections with the community is, from an empowerment perspective, more than a means of attaining specific social change goals. It provides group members with opportunities to begin to see themselves as members of a community and eventually to fully participate in the life of that community. In that sense, community work, whereby people collaborate to build supportive communities for themselves, goes hand-in-hand with empowerment work (Ledwith & Springett, 2010; McKenzie, 1999).

Finally, to attain their purpose, empowerment-oriented groups, like all groups, have to contend with the institutional and organizational structures in which they operate. Empowerment work requires ensuring the support of the administrators and managers of social services organizations and confronting organizational structures when they prevent groups from fully participating in decisions that affect them (Bartle, Couchonnal, Canda, & Staker, 2002; Gutiérrez, GlenMaye, & DeLois, 1995).

INTERVENTION/COLLABORATIVE ACTION

From an empowerment perspective, which posits an equalitarian frame of reference, it is more accurate to conceptualize the work that takes place as collaborative action rather than “intervention”—the latter conveys the idea that experts intervene or act while ordinary people are intervened with or acted upon (Breton, 1992). In empowerment work, this collaboration takes place from the very beginning, that is, from the planning stage, through the conscientization stage, the collective action stage, and the postgroup stage of embeddedness in the community.

Planning

In an empowerment-oriented group, it is imperative that everyone who will be involved in the group has the opportunity to share the power to define what the group will be about and what it will do (see Wright, 2014). Before the formal start of a group seeking the empowerment of African American custodial grandparents, for example, informal discussions to explore topics that would be interesting and useful to participants were held between potential members and group leaders (Cox, 1988, 2002; Gutiérrez, 1990). In other words, the “identification of needs” component of classic group planning (Kurland, 1978) is seen, in empowerment work, as the initial occasion for members to have a say, acquire a voice, and name their world. To share the power to shape the group requires that social workers trust the potential group members, respect their views, and acknowledge that they know best their own situations (Mullender & Ward, 1991).

Planning also involves deciding who will be in a group. This can be done in a more or less democratic fashion, from the worker choosing individuals and inviting them to join a group to announcing, in one form or another (e.g., ads in local papers, flyers, posters, word of mouth), that there is an intention to set up a group to holding a public pregroup meeting to which people can choose to come for the express purpose of sharing ideas about the prospective group. The more democratic the selection of members, the more empowering the selection process is for the potential members. Participating in that process also establishes that decision making in the group will be democratic and that group members will be expected to voice opinions and make responsible choices—liberating behaviors that are necessary components of empowerment.

Sharing ideas about the overall purpose of the group means, from an empowerment perspective, that workers and potential members recognize that the work of the group will involve both personal and social change. The specifics of these change goals will develop as the group develops, but the general notion that the group will involve not only thinking and talking about issues but also doing something about them has to be acknowledged from the beginning. The idea of praxis (Freire, 1970/1993) is introduced, even if only in an indirect and very general way, from the inception of the group, in addition to the idea of social justice.

In order to make the case for both personal and social change goals, workers must be clear in their own minds about the values on which empowerment work is based. Social justice is central to empowerment and needs to be identified as such by everyone. Concern about just and unjust social conditions has to inform the discussion of what the group will be about, even though it will do so in a precursory fashion at this stage.

Another point that needs to be touched on is that pursuing social change and social justice goals entails risk taking of a different nature—more public, involving more wide-range

environmental side effects or externalities—than the usually more private risks attendant to personal change goals. Workers need to introduce the idea of risk taking as a group norm that members will have the opportunity to uphold in the group. Publicly recognizing that aversion to risk taking is a natural motivation (Breton, 1985) can help workers and potential members alike to confront their reservations about social change efforts (Wohl, 2000).

At this early stage, workers and potential members will also recognize conflict as a standard group feature from which they can learn. Confronting and dealing constructively with the interpersonal conflict bound to occur in the planning stage is a first step in preparing the group to eventually confront oppressive social structures and policies.

Clarifying the kinds of roles to be expected in an empowerment-oriented group is also part of the planning stage. As in any mutual-aid group, roles such as enabler and advocate are shared between all group participants. Remembering that negotiating skills are important to empowerment (Garvin, 1997), workers and potential members will take the opportunity provided in the planning stage to begin to negotiate roles and the meaning of shared responsibility for role taking.

Empowerment is not something achieved quickly. This means that, from the start, the organization, the workers, and the potential members recognize that supporting or participating in an empowerment-oriented group requires a significant commitment in terms of time. Without that commitment, the group will be set up for failure.

A successful planning stage involves preliminary but careful consideration of all these issues. This prepares the group to engage productively in the next stages.

Consciousness Raising/Conscientization

In this stage, collaborative action begins with the group engaging as a system of mutual aid. The mutual aid dynamic of exchanging personal information or stories is the means through which members first discover that they can help each other (see Steinberg, 1997). In empowerment-oriented groups, the dynamic will also be used deliberately as the medium through which members either discover that they have voices, acquire voices if opportunities to be heard have always been denied them, or repossess their voices if they have been silenced. That is the beginning of discovering that they have a say and that they can influence others.

When the stories exchanged are received with respect and recognized as “legitimate knowledge” (Weick, 1992, p. 23), opportunities are created to explore and substantiate the members’ competence and strengths (often simply as survivors, to begin with). Recognizing that they have something to say that is of genuine interest and help to others and that they have some degree of competence facilitates the cognitive restructuring process of challenging their negative self-images and self-evaluations, an initial part of consciousness raising.

To eventually lead to empowerment, however, consciousness raising cannot be conceptualized as a strictly personal process of cognitive restructuring whereby views of oneself and the world change. Consciousness raising must also involve an awareness that negative views of self are connected to social, economic, and political forces. That awareness is promoted when group members see the common patterns in their individual stories. This is an example of “the exceptional goodness of fit” between group work and empowerment or antioppression work (Steinberg, 2010, p. 57).

Consciousness of the interconnections between issues, though essential, is only a first step (a “naïve” awakening to reality, as Freire [1970/1993] points out). It must be followed by an awareness of both the internal and external blockages that keep people from having

control of their lives and the consequent need for change at the personal, interpersonal, and sociopolitical levels (Cox, 1991; DuBois & Miley, 1999; Gutiérrez, 1994; Lee, 2001). In other words, consciousness raising that leads to empowerment is not only a personal process of cognitive restructuring but a politicization and liberation process that creates a demand for sociopolitical or systemic restructuring. That is the essence of conscientization. The difference between consciousness raising and conscientization may offer a clue as to why a study would conclude that “even the linkage of personal to political issues . . . has fostered a renewed emphasis on individual rather than collective solutions to social issues (Reisch, 1998)” (Andrews & Reisch, 2002, p. 7; see also Breton, 2006).

Going through the conscientization process, members begin to identify themselves as citizens—political beings—who, in a democracy, have the right and responsibility to participate on the sociopolitical scene, to be heard, and to influence policies so that they can gain access to the resources they need. This situates them in a position from which they can move to the next stage of empowerment work, that of taking collective action to change their situation of disempowerment.

Social/Collective Action

As Rappaport (1981, p. 13) put it: “Having rights but no resources and no services is a cruel joke.” This is why empowerment work cannot stop at the stage of conscientization. The challenge of this next stage is to build on new perceptions of self and society in order to bring about targeted, specific changes that will permit access to needed resources.

As it is natural for group members and facilitators alike to experience some trepidation at the idea of getting politically involved, groups must first mobilize and prepare to take action. At this point, the “strength-in-us” dynamic of mutual aid can be channeled to act as a motivator (“We are all in this together”) and as a reality test (“Let’s see how we can use our collective voice”).

Once mobilized, groups decide on the action(s) to be taken. This step is crucial, for taking action will lead to empowerment only when the people involved in the action have had a say in deciding what action will be taken and have weighed the costs, in terms of energy, time, possible conflicts, and consequences of taking a particular action (Breton, 1995; Garvin, 1991). It is only then that action becomes responsible and autonomous.

As part of evaluating these costs, groups will question whether they have the support of the communities to which they belong. Creating community alliances is an effective means of getting that support and of lowering the costs of taking action (Breton, Cox, & Taylor, 2003). It is also a means of creating long-term solidarities between group members and their communities, which will eventually affect how the newly empowered become embedded in society (see Jacobson & Rugeley, 2007; Staples, 2009).

The types of action taken will depend on the sophistication, skills, and abilities of the group members. Actions may include taking part in demonstrations; giving interviews to newspaper, radio, or television reporters; participating in town hall meetings; leading or coleading seminars; and writing letters to the editor or newspaper articles. These undertakings should also be geared to leading the public and government policy makers (civil servants and politicians) to begin their own process of conscientization (Breton & Breton, 1997).

To be empowering, any action must be followed by reflection; it must involve what Freire (1970/1993) calls “praxis,” that is, a constant movement from reflection to action back to reflection. It is through assessing the results of their action that group members

acquire an increasingly critical consciousness of the workings of power in their environment and society. As Breton (1994a, p. 25), following Freire and Longres and McLeod (1980), has argued: “Action without reflection is not autonomous and authentic action, but rather a *reaction* to others’ ideas, while reflection without action is, for the disempowered, mere teasing or provocation, akin to adding insult to injury.”

As they reflect on the action they have taken, groups must decide whether they are satisfied that they have been heard. In the latter instance, they will design and adopt strategies that will elicit attention and “force” the community and politicians to listen. Such strategies often involve some form of confrontation, as when a group of homeless women and men pitch a tent on a courthouse lawn (Sacks, 1991).

Having got the attention of the public and policy makers, the group’s action now shifts to lobbying in an organized fashion and to formulating precise demands for legislation, policies, and services. Applying focused pressure is a skill that the disempowered need to develop to become empowered. It will be more easily acquired if members have learned, from the earliest stages of the group, to formulate as precisely as possible what they want, what means they are ready to take to get what they want, what costs they are prepared to pay, and so forth. As the members gain experience in seeing their requests attended to seriously, and as they begin to participate in earnest in the democratic political process, they become empowered.

This does not mean that they will obtain everything they demand; participating in the democratic process does not, nor should it, guarantee this. It does mean, however, that their actions have the same probability of succeeding as those of other groups in society who are seeking their fair share of resources.

Embeddedness in the Community

Empowerment-oriented groups, though long-term groups, eventually come to an end. As for all groups, the end phase is associated with the question of how best to ensure that the gains achieved through the group will endure. Once the group terminates, ex-group members cannot protect, consolidate, and build on these achievements if they are socially isolated; they need a supportive environment. They need, just like any empowered person, to be embedded in a community. Embeddedness is taken here in its original sense of rootedness and interdependence and does not connote the subservience and dependence with which the word became associated when reporters were attached to military units in the 2003 invasion of Iraq. Being rooted in, or being part of, a community is a safeguard against the social marginalization that plagues the disempowered.

All means of becoming embedded in a community require some degree of participation in the affairs of that community. To consolidate and build on the gains made in empowerment-oriented groups, a typical strategy is for ex-members to join or be incorporated into the organizations that hosted the groups. This may mean that they become employees of the organizations; that they become volunteers, peer supporters or coleaders of groups; that they become spokespersons for the organizations at conferences or trainers in educational programs (Cox, 2002); or that they get elected to boards of directors (Cohen, 1994). Another typical strategy is for ex-members to become active in other community institutions or organizations or make use of community resources, such as community colleges. The affirmation and testing of strengths and abilities provided through empowerment-oriented groups often act as the trigger that releases the energy and courage of ex-members to go back to school—thus safeguarding themselves against the economic

marginalization that so often goes hand in hand with lack of schooling. Ex-members can also consolidate gains made at the political level by joining existing lobbies or advocacy organizations. Cox (2002, p. 52) writes about a grandparent who, having graduated from an empowerment training group program, spoke up at a public meeting on changes in social services agency priorities and “demanded to be placed on an advisory board so that she could have direct involvement in policy.”

CONCEPTUAL FOUNDATIONS OF EMPOWERMENT

As Gil (1998, p. 1) has pointed out, “Social workers and social policy professionals have always been involved with victims of injustice and oppression.” This involvement, however, has not necessarily translated into confronting injustice and oppression directly. Such confrontation, it is fair to say, is not at the core of the practice models most favored by the profession. It is at the core of empowerment-oriented group practice.

Social Movements

One can trace some of the philosophical bases of empowerment-oriented group work to the three social movements that were seminal influences on the development of social group work: the *settlement house movement*, the *progressive education movement*, and the *recreation movement* (Breton, 1990). The first of these movements categorically stood for professionals throwing their lot with the people they wanted to help, sharing their lives, refusing to distance themselves from the people, refusing to separate personal issues and problems from social, economic, and political issues and problems, and getting involved in community and neighborhood concerns in an immediate and concrete fashion. These professionals “chose to perceive people not only as individuals but as members of social groups and cultures affected by the social, economic and political conditions in which they live” (Breton, 1990, p. 22). They believed that when these conditions were unjust, the people themselves should get involved in efforts to change the conditions, and they facilitated that involvement. They shared the view of contemporary liberation movements that it is not good enough to learn about different groups and cultures; one has to learn *from* different groups and cultures.

The progressive education movement was influenced by Dewey’s (1922) philosophical positions on ideal forms of government and his views on citizenship. It led group workers to perceive the small group as an experience that prepared members to participate in the democratic affairs of the community. Providing opportunities for people to learn to become citizens and to learn the importance of citizenship was a central preoccupation of group work pioneers such as Jane Addams, Mary Parker Follett, Eduard Lindeman, and Grace Coyle (Shapiro, 1991). Their thinking is relevant to a contemporary practice perspective that is diversity-based and multicultural. As Shapiro (1991, p. 9) notes, “A distinctive aspect of their ideas was an emphasis on the role of groups and voluntary associations in a pluralistic society. Groups would provide an arena within which individual interests and differences might be ‘socialized’ (to use Jane Addams’ term) and mediated.”

As the settlement and progressive education movements drew attention to the social and political selves, the recreation movement directed group workers to pay attention to the whole self. That is a focus that, in its emphasis on the “deep delight available in the mutual

interactions of a democratic and creative group” (Coyle, 1947/1955, p. 96), anticipated the strengths perspective, for it recognized the innate potential of human beings and their immense capacity for growth when not stigmatized with labels or stuck in sick roles. Groups were structured “so that the whole person in each member [was] invited to participate, [not only] the troubled, or broken, or hurt part” (Breton, 1990, p. 27).

The influence of the conceptual and philosophical premises of the early social movements of the 20th century on empowerment-oriented group work has been followed by that of contemporary liberation and other social movements. These movements include:

1. *The critical/radical practice movement* (Galper, 1980; Gil, 1998; Jacobson & Rugeley, 2007; Longres, 1996), which emphasizes institutional and social change and redefines the client–professional relationship as a partnership and expertise as a shared resource—not the exclusive property of the professionals.
2. *The self-help movement*, which points up the iatrogenic effects of the helpee’s role and the obverse beneficial effects of the helper’s role (Gartner & Reissman, 1984; Reissman, 1990).
3. *The feminist movement*, with its insights into gendering processes, the workings of privilege and oppression to the detriment of women, and the conceptualization of power not as hierarchical but as collective (see Butler & Wintram, 1991; Garvin & Reed, 1995; Pollio, 2000; Saulnier, 2000; Weick, 1982).
4. *The critical consciousness and radical pedagogy movement* (Freire, 1970/1993, 1990; Kieffer, 1984), which engages people’s ability to critically perceive their relationships with the world in which they live, as well as their ability to critically act on that world, and sees the education process as a dialogue—as opposed to the “banking notion” of education, in which the ones who know deposit that knowledge into empty vessels (see also Hegar, 2012; Ledwith & Springett, 2010).
5. *The multicultural and diversity movement*, which calls attention to the special strengths of ethnic, cultural, and other distinct groups and eschews paternalistic approaches (McKenzie & Morrisette, 1993; Sansfaçon, Ward, Robichaud, Dumais-Michaud, & Clegg, 2014; Spencer, Lewis, & Gutiérrez, 2000).
6. *The community-building movement*, which shifts the emphasis from community organizing led by professionals to community building led by members of the community—thereby highlighting both participation *and* accountability by treating community members as equal partners in social enterprises (Ewalt, Freeman, & Poole, 1998; Pyles, 2009; Staples, 2009; Weil, 1996; Zippay, 1995).
7. *The strengths perspective*, which is implied in all the above movements (Saleebey, 1997; Weick, Rapp, Sullivan, & Kisthardt, 1989). It is built on the premise that individuals and communities have strengths and resources. As Swenson (1998, p. 530) put it succinctly, “Without a strengths perspective, social workers are left with theories that pathologize, emphasize deficits, and ‘blame the victim.’”

Major Themes

Many common themes emerge from the ethics or moral philosophy that underlies the preceding social movements, young and old. The themes all relate to empowerment-oriented group work, for they all ensue from the moral precept to fight oppression and social injustice. Because of space limitations, only a few selected themes are discussed here.

Power

Essential to understanding empowerment is confronting questions such as: Where does power come from? How is it used by social work professionals and organizations? Can it be shared?

In their influential work on the sources of social power, French and Raven (1960) identify and analyze five of the most common and important bases of power. These are: (1) reward power, (2) coercive power, (3) legitimate power, (4) referent power, and (5) expert power. Their analysis can be used to shed light on empowerment-oriented group practice.

The first point to note, because it is relevant to cognitive restructuring and the consciousness-raising process, is that French and Raven (1960) hypothesize that power is exerted on a person because that person *perceives* that the one exerting the power has the ability to mediate rewards (reward power), the ability to mediate punishment (coercive power), the legitimate right to prescribe behavior (legitimate power), or some special knowledge or expertise (expert power). Referent power is based on a person's identification with the one exerting power, a psychological mechanism that calls to mind the "oppressor within" construct.

To signal the importance of perception in power relationships does not imply that consciousness raising (which involves a change in perception) leads to ignoring the real power that people or organizations possess because they control critical resources or because they have abilities, knowledge, and socially, politically, or culturally sanctioned statuses and rights. What consciousness raising does is get people who previously thought of themselves as powerless to realize that they, too, have power because they, too, control resources and they, too, have abilities, knowledge, and rights. Through the process of consciousness raising, the disempowered broaden their perception of power to include their own heretofore unacknowledged power. In that sense, empowerment is a matter of equalizing or rectifying power imbalances. It is not a takeover of power; it does not require disempowering those who are already empowered; it means sharing that power by becoming empowered.

To argue that the disempowered have resources may seem to contradict the very notion of oppression unless the distinction is made between positive and negative sources of power (Wax, 1971). When people have insufficient positive sources of power, such as the ability to reward, they can use negative sources of power. The main source of negative power is the ability to withhold consent, support, or participation. Withholding does not imply passive behavior. It often involves some form of confrontation, such as the use of obstruction to influence the relative costs of projects (cf. O'Sullivan, Waugh, & Espeland, 1984).

The second point to be drawn from French and Raven's (1960) theory relates to referent power. The importance of understanding and using mutual aid dynamics in empowerment-oriented practice has been mentioned previously. What can be derived from the analysis of the bases of power is that a mutual aid group per se has the essential elements to become a significant referent group for its members (Shapiro, 1990; Sherif & Sherif, 1964). When a reference group is also empowerment oriented and addresses the issue of the "oppressor within," it has the opportunity to substitute for that internalized oppressor a group of peers perceived as equal partners striving and helping each other to gain control over their lives.

Power issues exist in any empowerment-oriented group facilitated by professional social workers. Hasenfeld (1987), discussing power as an integral and neglected component of social work practice, argues that the main source of social workers' power is that they are members of an organization that controls critical resources and services needed by clients. Members of empowerment-oriented groups know this, as do the social workers who

facilitate such groups. The organization can withhold rewards and mete out punishments to both. But then group members and staff can withhold consent, support, and participation in the organization's operations and programs; they have and can use negative power. As this use of power will probably entail confrontation, the attendant risks must at least be acknowledged, as mentioned earlier, from the beginning of the group.

Self-determination, that hallowed social work construct, is by definition connected to power and control issues and therefore is highly relevant to empowerment. Haynes and Mickelson (1997) have argued that because self-determination is perceived in social work at the micro, as well as at the macro, level as an absolute, it is largely irrelevant in terms of real practice and power relationships, both of which involve compromise. To be serious about empowerment, the social work profession needs to rethink and reevaluate self-determination so as to make it a truly applicable and honestly applied value.

Social Justice

Philosophers such as Rawls (1971) and Sen (1999) have made major contributions to theories of social justice, and social work theorists have identified and analyzed core issues in terms of the application of social justice concepts (see Swenson, 1998; van Soest, 1995). Hefernan, Shuttlesworth, and Ambrosino's (2001) proposition that social and economic justice includes fairness and equity in regard to basic civil and human rights, protections, resources and opportunities, and social benefits encompasses the concerns of empowerment-oriented group practice. The proposition helps to explain why social justice is being considered as the organizing value in social work (Wakefield, 1988).

There is a paradox in that consideration, for social policy receives relatively little of the profession's attention. "Yet social injustices cannot be dealt with in any significant way without dealing with the policies that create or exacerbate them, nor can social justice be pursued effectively without promoting just social policies" (Breton et al., 2003, p. 4). The paradox is related in part to social work history. In the process of becoming a profession, social work decided in essence to favor psychology and psychiatry as foundational knowledge. That decision was a costly one, as it resulted in the neglect of sociology, economics, and political science, which are important to understanding and assessing social and economic policy and to engaging in policy making (see Breton, 2006).

In order to work effectively toward the implementation of just and equitable social policies, social workers and members of empowerment-oriented groups need to be able to contextualize problems in terms of their social and economic origins and their ramifications in a specific social and economic environment. Contextualizing socioeconomic problems does not require the ability to use the tools of economics. It does require understanding an economic approach to problems and being able to make sense of and to criticize interpretations of raw data on such things as affordable housing or unemployment or poverty in a given metropolitan area. Inability to contextualize socioeconomic problems—because it leads to inadequate assessment of these problems and therefore to arbitrary and poorly conceived efforts at policy making—will tend to relegate social justice to the status of a revered but nonoperationalized value.

Radical Pedagogy

Radical pedagogy has been referred to previously; its importance to empowerment warrants further elucidation. Paulo Freire (1973/1993), the foremost exponent of this pedagogy,

sees education as the practice of freedom—freedom from the culture of silence in which oppressed people live, freedom for people to have their say, freedom to name the world. He rejects conventional education, which he identifies as a taming process through which people learn to conform and are assimilated into the prevailing system.

On the contrary, radical pedagogy presumes that educators enter into a dialogue with “educands,” become partners, and act as problem posers, not problem solvers. Freire assumes further that educators must acknowledge and respect the “knowledge of living experience”—and in this he antedated the narrative approaches so popular today (see White & Epston, 1990), as well as the strengths perspective. He cautions, however, that that knowledge is not the *only* knowledge people have a right to access. It is in this context that Freire assumes that educators should present their “dream” to people, who all have a vocation to “be more,” to be subjects who act on and transform the structure of oppression.

Based on these assumptions, Freire (1973/1993, p. 55) develops his theory of conscientization as a process through which the oppressed, who are “beings for others,” become “beings for themselves” and his complementary theory of praxis, in which reflection and action belong to the oppressed themselves. As he put it (p. 60), “Liberation is a praxis: the action and reflection of men and women upon their world in order to transform it.” Freire is uncompromising in his position on the need for both reflection and action. Twenty years after writing *Pedagogy of the Oppressed*, he scathingly observed that when consciousness raising produces change “only in the interiority of awareness [and] the world is left untouched,” it produces “nothing but verbiage” (Freire, 1994, p. 104). That the oppressed must be the agents of their own liberation is the central hypothesis of all liberation theories and, ipso facto, of empowerment theory.

Liberation Theology

Boff and Boff (1987, p. 3) write: “Liberation theology was born when faith confronted the injustice done to the poor.” They add that it is “a broad and variegated phenomenon [which] encompasses a wide range of ways of thinking the faith in the face of oppression” (p. 14) or simply that it is “faith confronted with oppression” (p. 12). In this theology, the word *liberation* is taken for what it is: “the concept of a historical reality, the reality of the social emancipation of the oppressed” (Boff & Boff, 1984, p. 81).

Liberation theologians assume that liberation presupposes a commitment to the poor and oppressed: “Commitment is the first step” (Segundo, 1976, p. 81). Early on, they recognized that this commitment required them to confront a powerful institution and its vested interests. They also assumed that both a commitment to the oppressed and a challenge to the institutional status quo meant being ready to use “the mighty weapon” of politics (Boff, 1977/1986, p. 43). They assumed, in effect, that there can be no liberation theology without a liberation praxis, that is, without taking actions that lead to the liberation of the poor and oppressed.

Following Freire—they acknowledge owing much to his pedagogy of the oppressed and not *for* the oppressed—they insist that it is the oppressed themselves who must become the primary agents of their own liberation. Liberation is not occupation: The powerful cannot occupy or take over from the oppressed the task of becoming enfranchised, liberated, or empowered.

Thus the liberation theologians’ challenge to institutional power involves a challenge to the power of clerics, that is, professionals, to speak for the people. As Boff (1977/1986) observes, when people have the opportunity to have a say, the monopoly of experts on

speech is over. Insisting that the oppressed speak for themselves assumes that they have resources that can be mobilized to begin a process of change. An “assistentialist” stance of helping people in need is to be replaced by a partnership stance of working with people who have not only needs but also resources and rights. It is not a question of ignoring needs. On the contrary, Segundo (1976, p. 41) stresses that liberation theology arises out of “the urgent problems of real life.” Those problems, however, “are definitely not tackled on a plane of certain knowledge . . . science [cannot] provide any ready-made option in advance” (Segundo, 1976, p. 76). Scientists, experts, professionals, are not in possession of incontestable knowledge that allows them to speak for the oppressed.

The change advocated by liberation theologians is not reform but transformation of the system. They assume that reformism, synonymous with timid measures, is insufficient in the long term and counterproductive in achieving a genuine transformation (see Breton, 1989). They are aware that the transformation of the system will not necessarily bring about a richer society but a more just, fraternal, and participatory society (Boff, 1985). Finally, liberation theologians assume and caution that liberation involves long-term work: “a journey of resistance and struggle, not of facile enthusiasm” (Boff, 1977/1986, p. 43).

Mutual Aid Groups and Organizations

In order to develop a sound theory of empowerment, some assumptions about mutual aid groups and about organizations must be added to those about power, social justice, education, and liberation. It is widely assumed that empowerment is facilitated through membership in an empowerment-oriented mutual aid group housed in a supportive organization (see Bartle et al., 2002; Gitterman, 2010; Gutiérrez et al., 1995; Home, 1991; Lee, 2001; Longres & McLeod, 1980; Steinberg, 2010).

In terms of groups, the following assumptions can be made:

1. When a group becomes a system of mutual aid, the power imbalances between professional facilitators and group members are significantly reduced because everyone becomes a helper.
2. There is, in groups, a better chance of seeing how private troubles and public issues are connected. When private troubles become shared troubles, their structural (i.e., nonpersonal) sources can be more easily identified.
3. The realization that one belongs to a particular class comes more naturally in mutual aid groups, in which one is face-to-face with others who are identified as being “in the same boat.”
4. The disempowered or disenfranchised need a context in which to realize that they have a voice and a say, and the optimal context for this is a group in which they share their stories, debate issues, and make decisions.
5. Although it is possible to create such a context in a one-on-one situation, the outcome of individuals asserting their voices among a group of peers is that they develop that essential component of empowerment that Kieffer (1984) called “participatory competence”—the ability to participate in a common enterprise.
6. Mutual aid groups facilitate the action phase of empowerment work (Cox, 1991; Lee, 2001; Shapiro, 1991) through the mutual aid dynamic referred to as “the strength in us,” which makes it easier for group members to mobilize for and take action. (See Gitterman, Chapter 7, this volume, for a detailed discussion of the mutual aid approach.)

Assumptions about organizations that are relevant to a theory of empowerment can be derived from the research literature (see Bartle et al., 2002; Gutiérrez et al., 1995; Mullender et al., 2013). They include the following:

1. Because empowerment involves sharing power, and therefore challenges established power structures within organizations, organizational barriers to empowerment are to be expected.
2. Because one of the organizational barriers to empowerment concerns the expectations of funding sources, organizations have to be ready to work around the rules of funders (see Bartle et al., 2002).
3. Practitioners who regularly interact with many organizations will hesitate to refer people to one that is hostile to the empowerment approach or that is simply very conservative and traditional (because they know it is service users who bear the costs of inconsistencies in approaches); this will tend to isolate empowerment-oriented organizations.
4. To fight isolation, empowerment-oriented organizations need to network and support one another.
5. Three types of organizational support are crucial to empowerment-oriented work: staff development, a collaborative or team-like approach, and administrative leadership and advocacy (Gutiérrez et al., 1995).
6. Because empowerment looks different in different contexts and even settings (Rappaport, 1985; Saleebey, 1997), organizations have to be innovative and open as to the form empowerment will take in their own settings.

FUTURE DIRECTIONS AND CONCLUSION

It is clear from this discussion that changes in the delivery of social work services would help to consolidate an empowerment approach in group work. In order to put social justice at the center of group work—addressing social policy issues and engaging in social action as normal, not exceptional, practice—the boundaries between levels of practice must be opened up (Breton et al., 2003; Cohen & Mullender, 1999). What Reid (2002) identifies as a trend toward multilevel intervention or integration needs to develop into a commonplace reality. This would lead to more systematic engagement of social work groups with the communities in which they operate. In that sense, the trend toward community-based practice dovetails with an empowerment-oriented group approach in that both stress the importance of partnerships with and within communities (Ewalt et al., 1998; Weil, 1996; Zippay, 1995). So too does the trend toward mandated collaboration between social services and communities (Bailey & McNally Koney, 1996).

Another change that is of the essence relates to power-sharing arrangements within social work organizations. Though conditions for the establishment of empowering organizational practices have been spelled out and examples documented (Gutiérrez et al., 1995; Shera, 1995), evidence of power sharing is still scarce. This may be due in part to the prevailing educational culture within schools of social work, a culture that would benefit from integrating a strengths perspective and creating an empowering environment.

The trend toward establishing consumer rights in social and mental health services has helped to foster, and is bound to help maintain, an empowerment perspective in these services (Staples, 1999). It is crucial to emphasize that a device such as a bill of rights for

group members must have an enforcement mechanism if it is to be empowering. Without institutional measures guaranteeing its implementation, a bill of rights may make group members *feel* empowered or have a *sense* of empowerment; it will not mean that they have more control over what happens to them in a given institution. If it is not enforced, it may lead to disillusionment, disappointment, and further disempowerment.

Finally, the recognition and acceptance of participatory research is an indication of growing professional respect for the contribution of service users and has the potential, when used appropriately, to strengthen empowerment-oriented group practice (see Alvarez & Gutiérrez, 2001; Cox & Parsons, 2000; Jacobson & Rugeley, 2007; Sansfaçon et al., 2014).

This brief look at future directions has been, on the whole, optimistic. It would be misleading, however, not to mention two negative trends that are gaining ground in the social services and that could seriously threaten empowerment-oriented practice. First is the trend toward managed care and all forms of divestment of public, not-for-profit services onto the private for-profit sector. It has been stated more than once throughout this chapter that empowerment is achieved after a usually lengthy process of conscientization that leads to usually lengthy participation in a collective/social action. Empowerment work is not suited for short-term intervention that produces quickly reached goals. And it is obviously not suited to the preservation of the sociopolitical, organizational, or institutional status quo. The second trend is identified by Gitterman (2010) as the reliance on manualized didactic material, which, if not checked, he concludes, will reduce group work to a means of social control as opposed to empowerment. Those who want to engage in empowerment-oriented group practice need to come to terms with these realities.

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CHAPTER 5

Ethics and Values in Group Work

ALLAN EDWARD BARSKY
HELEN NORTHEN¹

The Code of Ethics of the National Association of Social Workers (NASW, 2008) identifies the core values of social work as service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These values define what the profession deems to be good, aspirational, or worthy to pursue (Dolgoff, Harrington, & Loewenberg, 2012). Each standard in the NASW Code is guided by one or more of these values, translating broad notions of what the profession deems desirable into more specific behavioral guidelines to delineate and promote ethical social work practice. Social work is a value-driven profession, meaning that all aspects of social work practice are guided by these core values. In other words, when social workers decide how to engage, assess, and provide services with clients, their decisions take their core values into account (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013). Social work with groups is certainly no exception. Although the NASW Code applies to all levels of social work practice, the unique nature, processes, challenges, and opportunities of group work are not necessarily apparent in nor encapsulated by the values and ethical standards expressed in this code (Barsky, 2014). In contrast to social work with individuals, applying values and ethics in social work with groups is complicated by having more than one person in the client system; having multiple people means the worker needs to accommodate different client goals, beliefs, values, language, culture, interests, strengths, and challenges among members. This chapter explores ethical issues that may arise in group work in relation to each of the core values of social work, demonstrating how to understand and differentially apply social work ethics in the context of group work. This chapter refers to the NASW Code of Ethics, as well as to the practice guidelines of the International Association for Social Work with Groups (IASWG, 2010), which build on the NASW Code of Ethics, providing guidelines specific to group practice. For the sake of brevity, the term *Standard*

is used in this chapter to connote standards from the NASW Code. Although the NASW and IASWG codes are based on many common principles, there may be times when social workers may have to deal with conflicting guidance from these or other relevant professional codes (Barsky, 2016).

Before addressing particular values and standards, it is useful to distinguish between ethical principles, ethical standards, ethical breaches, and ethical dilemmas. *Ethical principles* are broad guidelines that define right and wrong behavior (Dolgoff et al., 2012). Deontologists² such as Immanuel Kant suggest there are certain principles, or categorical imperatives, that people should follow regardless of the situation. For instance, people should be honest, respectful, and caring. *Ethical standards* are more specific behavioral guidelines that denote how people should behave in particular situations. Thus the broad principle of respect is the basis for the ethical standard that social workers should honor a client's right to self-determination (NASW, 2008, Standard 1.02).³ *Ethical breaches* are clear violations of ethical principles, for instance, a worker who violates client confidentiality (Standard 1.07(c)) by sharing personal client information on Facebook or another public forum. *Ethical dilemmas* are situations in which social workers, clients, or other actors must choose between various courses of action, but there are ethical risks to each course of action (Reamer, 2013). Ethical dilemmas often arise when there are conflicting ethical obligations, such as a group facilitator's obligations to group members, as well as to his or her employer (Barsky, 2017). Ethical dilemmas also occur when social workers and members are operating on different values or morals, or when ethical guidelines do not clearly establish what a social worker should do in a particular situation. The following sections provide examples demonstrating how ethical breaches and dilemmas may arise in group practice. The final section provides a process-oriented approach to help social workers and groups manage ethical dilemmas, such as those identified in earlier sections.

SERVICE

The fundamental value of *service* suggests that social workers honor the needs and wishes of others, offering and providing help to meet the needs and wishes of their clients. Standard 1.01 of the NASW Code operationalizes this value, stating that social workers' primary commitment is to their clients. Social workers facilitate a broad range of groups, including support groups, educational groups, counseling groups, and therapy groups, for client needs as disparate as addictions, family transitions, end-of-life decision making, trauma, healthy lifestyles, child development, and public speaking. Standard 1.01 is violated when a worker puts the needs or wishes of others above those of the clients—for instance, missing a group session to go fishing or refusing to facilitate a group for people living in poverty because serving a wealthy population is more lucrative.

In some instances, the *duty to serve* conflicts with other duties, including obligations to employers or to society in general. Consider a request to facilitate a group for people who self-identify as “neo-Nazi skinheads.” Although Standard 1.01 suggests workers should offer services, what if the agency has a policy prohibiting racism, religious bigotry, or other forms of discrimination favored by the skinheads? Does the duty to follow agency policy (Standard 3.09(a)) supersede the duty to serve all clients? Furthermore, does the duty to promote social justice (Standard 6.04(d)) take precedence over the duty to serve? If the worker helps the group, is the worker supporting its agenda of discrimination? If the worker denies

service, is the worker putting his and the agency's concerns above the needs of the group (Borrmann, 2005)?

SOCIAL JUSTICE

The value of *social justice* signifies social work's belief that every person deserves equal rights, liberties, and opportunities, without discrimination as to race, ethnicity, religion, socioeconomic status, sex, gender identity and expression, sexual orientation, health, abilities, and other aspects of human diversity. Social work has a historic alliance with people from vulnerable and disadvantaged groups, meaning that they pay particular attention to people affected by poverty, discrimination, mental illness, physical illness, unemployment, and other biopsychosocial challenges. As Standard 6.04(b) states, "Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups." Group work is particularly helpful for empowering and addressing the needs of such groups, as it provides a structured time and place for people from like backgrounds and interests to gather, to support one another, and to work together to address the problems they face, individually and as a group. Working in groups provides members with a sense of personal and collective power (Simon, 1994; Toseland & Rivas, 2017).

Although groups have the capacity to empower people and promote social justice, they also have the potential to block opportunities, exclude certain individuals or groups, or disempower them (Gutiérrez & Lewis, 1999). Consider, for instance, a group that refuses to admit members on the basis of their religion or sexual orientation. Does the group's right to self-determination include a right to exclude members based on discriminatory criteria? Alternatively, some group members may insult, dismiss, or demean other members due to race or political affiliation. If a facilitator allows or condones such acts, the worker may be in violation of Standard 6.04(d), which instructs workers to act in ways to prevent or eliminate discrimination. Although some forms of exclusion clearly violate social work ethics, other situations are less clear. Consider a group that wants to force one member out of the group on the basis of that member's perceived misbehavior (e.g., dominating discussion or not being honest with group members). While the group may have valid concerns, ousting the member may have a negative impact on that member (abandonment, alienation, lost access to the group's aid). It also denies the group an opportunity to learn how to work through conflicts in relationships.

A major challenge for promoting social justice in the context of group work is that different members (including the facilitator) may have different views of what constitutes social justice (Gasker, 2014). Consider a task group mandated to deal with problematic relations between police and the African American community. African American members may view the issues as police insensitivity, racial profiling, and use of unnecessary and provocative force. Police may believe that mistrust within the African American community is misplaced and that police are doing everything they can to protect the public while respecting the rights of African Americans. As a facilitator, should a social worker remain neutral, not siding with African Americans or with the police? If the worker remains neutral, then some might argue that the worker is not fulfilling his or her obligations to promote social justice under Standard 6.04(a). If the worker takes sides, others might argue that the worker is violating Standard 1.02, self-determination, by imposing the worker's views rather than allowing the group to reach its own conclusions.

DIGNITY AND WORTH OF THE PERSON

The value of *dignity and worth of the person* suggests that social workers believe that all people are worthy of dignity and respect, regardless of their values, beliefs, behaviors, affiliations, or social situations (Reamer, 2013). Thus all people should be accepted as they are, recognizing their strengths, as well as their limitations and challenges. Demonstrating respect (or unconditional positive regard) is a core condition for developing trust and a positive therapeutic alliance with clients. Thus respect for the dignity and the worth of the person is not simply an aspirational value but a necessary condition for effective clinical practice (Rogers, 1957).

Respecting the dignity and worth of group members is relatively easy when the social worker likes the members, shares common values and beliefs, and agrees with their goals and motivations. Being true to this value is more challenging, however, when the worker and members have conflicting values and beliefs (Gedge & Querney, 2014), when they disagree about the goals or purposes of the group, or when there is something about the group members that the worker does not like. To demonstrate respect and avoid nonjudgmental responses, social workers need ongoing self-awareness about their own biases, prejudices, and moral preferences. Workers should recognize that each group member's identity and behaviors may have particular psychological meanings for them; for example, interactions with various members may trigger reactions of fear, hostility, disgust, affection, or overprotection within the worker (Northen & Kurland, 2001). Workers need to learn to deal with such countertransference reactions so they do not interfere with their professional relationships with group members.

The following sections explore three ethical standards based on respect for the dignity and worth of all people: self-determination, informed consent, and confidentiality. These sections illustrate some of the opportunities and challenges for putting the value of respect into practice.

Self-Determination

To demonstrate respect for dignity and worth, social workers should honor the autonomy and choices of their clients; accordingly, they should avoid imposing values, beliefs, or interventions (Dolgoft et al., 2012). Serious injustice to clients' autonomy occurs when they are pressured into making decisions or performing tasks that are against their values or capacities. As Standard 1.02 states, "Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals." Unfortunately, the Code does not elaborate on how this standard applies to group work. Does self-determination refer to the decisions of the group as a whole, or does it require the social worker to ensure that each group member's choices are solicited and honored? Ideally, the social worker attends to the goals of both, having the group determine its goals by consensus and allowing group members to set their individualized goals within the framework of the group's goals. In many situations, the worker needs to balance the tension between collective and individual needs, interests, and wishes. Consider a trauma recovery group for female survivors of intimate partner abuse. All group members may be interested in topics related to physical and emotional abuse, but how should the worker respond if some members indicate they do not want to deal with sexual abuse? The right to self-determination does not mean that the worker should avoid intervening, simply accepting the wishes as initially expressed by group members (Kurland & Salmon, 1990). The worker may help

members explore their goals, feelings, and choices to help them process issues and develop solutions that meet the needs of the group and the individuals within it; for instance, members may have a choice about whether to participate in sessions related to topics that they do not wish to discuss. Participating in group processes provides members with an opportunity to explore themselves in connection with others (Toseland & Rivas, 2017); this includes working through differences that relate to having different concerns, goals, and beliefs. By working through these differences, group members may come to realize that they have more in common than they originally thought. Meeting the goals, needs, and interests of one client does not necessarily take away from meeting the goals, needs, and interests of another (Barsky, 2017).

Although self-determination is a central tenet of social work, there are many situations in which group members are referred to groups under some degree of pressure—for instance, under court order in a criminal court diversion or child protection case, under pressure from a spouse or other family member, or as an institutional requirement for schoolchildren, employees, military personnel, or other groups. To facilitate self-determination with involuntary or pressured individuals, the worker may focus on engagement skills, demonstrating empathic understanding, building trust, acknowledging the pressure to participate, and identifying goals that match interests of the clients. “I know you were referred as a condition of probation and I understand that you were not initially interested in attending this group [pause to allow responses]. Given that you are here, perhaps we can talk about the best way to use our time together. What are some concerns that you think would be helpful to discuss in our group?”

Although the worker should be honest about the structure of the group and potential consequences for not participating (Pollock, 2014), the worker can also enhance self-determination by offering choices of goals, topics, exercises, group guidelines, and other decisions that can be made by group members. Self-determination is not an either/or phenomenon. Social workers can foster some level of self-determination, even in situations in which choices are limited or there is pressure to participate.

The degree and manner in which social workers exert power is central to ensuring members’ rights to make their own choices, taking the context and abilities of the group members into account. Workers may use a range of facilitative and directive approaches:

1. *Reflective*: openly exploring issues or concerns with clients, facilitating decision making without offering specific directions or suggestions
2. *Suggestive*: exploring issues or concerns, offering a mild or tentative preference for a particular solution, and allowing clients to come to their own decisions
3. *Prescriptive*: allowing for input, but clearly directing a group with a specific course of action
4. *Determinative*: making decisions for the group and imposing them, without giving the group an initial opportunity for input or decision making (Rothman, Smith, Nakashima, Peterson, & Mustin, 1996).

The *reflective* approach honors self-determination to the fullest extent. The other approaches, however, might be ethically justifiable under certain circumstances. Consider a group for grieving elders. If the group is struggling with how to cope with losses, the facilitator might *suggest* certain evidence-based group activities that could be helpful. The group is provided with decision-making authority, and they benefit from the facilitator’s knowledge of evidence-based practice. One risk is that members may defer to the facilitator’s suggestions without fully understanding them; also, they may have been more empowered if the

facilitator taught them how to identify potential group activities rather than simply suggesting them.

In terms of *prescription*, workers often make decisions about the group during the early planning stages: What is the general purpose of the group, who should be recruited for the group, and where will meetings take place? Thus, determining the appropriate level of worker direction depends on the stage of group process. According to the principles of self-determination, social workers should enable the group to take responsibility for itself as soon as possible. Workers empower members with decision-making responsibility by providing them with time, space, information, and support, so that power gradually shifts from the worker to the group. Although the worker may initially prescribe the group's goals (perhaps as a condition for obtaining agency support and funding), the group can revisit these goals, refining or amending them. Social workers may also foster self-determination as they recruit or admit members. The worker informs the potential members about the nature of the group, its purposes, expectations, and structure. If a potential member has concerns about any of these factors, the worker can explain whether there is flexibility to accommodate the member's concerns. Alternatively, the worker can offer information about a more appropriate group for the client. Another option is to involve potential members or representatives in the preplanning stage of the group process. This strategy maximizes self-determination from the outset and fits with a social justice approach to group work (i.e., working from grass roots up, rather than top down).

From a self-determination perspective, the *determinative* approach should be avoided, as it does not provide clients with input into the decisions. However, there may be ethical justifications for using a determinative approach as a last resort. Some decisions are pre-determined by agency policy or relevant laws. Consider a private religious school that prohibits workers from discussing abortion with students. If members say they want to discuss abortion issues, the worker may remind them that the school prohibits such discussion. The worker could help them advocate for a change in policy or could refer them to other services outside the school (if the school permitted such referrals).

Thus, even when the worker uses a determinative approach, there may be ways to enhance client self-determination. Standard 1.02 also notes that limitations on self-determination may be justified if there is a serious, foreseeable, and imminent risk to self or others. For instance, if a group member is suicidal, the worker may need to place client safety above self-determination. Initially, the workers should try to engage the client on a voluntary basis, assessing and working with the client to create a safety plan. If the worker is not able to ensure the client's safety in this manner, the worker may need to initiate involuntary committal or other measures to safeguard the client from suicide.

Informed Consent

The ethical standard of *informed consent* builds on the principles of self-determination, honoring the dignity of clients by ensuring they understand the services being offered before giving them an opportunity to accept or reject them, without fear of coercion or negative consequences. As Standard 1.03(a) states:

Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent.

Informed consent to participate in groups may be complicated by the nature of group processes. During recruitment and pregroup processes, the worker may not be able to fully explain the purpose, risks, and so on, as many decisions about the group are still being formulated. Assume that the first person admitted to the group wants the group to be an open group, allowing new members to enter on a continuing basis. If the second and third persons then ask for the group to have closed membership (with a fixed number of members who commit to a certain number of sessions), the worker may have to go back to the first person to explain that other group members want the group to be closed.

Although some people think of informed consent as an agreement that takes place during the first meeting, the dynamic nature of groups requires informed consent to be an ongoing process. Group goals, activities, risks, and opportunities may change over time, meaning (1) the worker should ensure members are informed as changes are being considered and (2) members should have an opportunity to accept or reject changes as they are discussed. In practice, some groups have set goals, activities, and guidelines, with little opportunity for group members to have a say in the process. While this may simplify the informed consent process, it constrains client self-determination and empowerment.

Another aspect of informed consent within groups pertains to power relationships between members of the groups. Although the NASW Code says that *social workers* should respect client rights, including informed consent and self-determination, the Code does not govern the behavior of *members*. Consider how power and politics within groups may affect each member's ability to provide free and informed consent. Assume that a group for caregivers of people with Alzheimer's disease is discussing whether to have a session that includes their loved ones who have Alzheimer's. The first two speakers, who tend to dominate the discussion, say this is an excellent idea. Other members remain silent. Silence does not equate to consent, so the worker should inquire about their thoughts.

In groups in which one or more members might feel intimidated by others, the worker may need to meet individually to discuss their concerns. Even if all members appear to be in agreement, note that some may be feigning agreement out of fear. Thus workers should assess whether consent is being provided on a voluntary basis. They should also make provisions for people to contact the worker outside of group if they have any concerns that they may have difficulty discussing in front of others.

A critical component of informed consent is that members have sufficient mental capacity to provide consent. Young children, people with severe dementia, and other people with significant cognitive impairments may not provide informed consent. A parent, guardian, or other legally authorized proxy should provide consent on their behalf. Note that even when certain clients are unable to provide legally enforceable *consent*, they should be offered an opportunity to provide *assent* (National Cancer Institute, 2014).

In a play therapy group, for instance, parents may provide consent for the child to participate in the group. For various group activities, however, the facilitator should check with each child member to see if the child agrees to participate. Depending on the context (including agency policies, legal framework, and cognitive abilities of the children), the facilitator may be able to empower group members to make many decisions pertaining to the group's process. Consider an adult member of an addictions treatment group who comes to a session while intoxicated. If the member's intoxication is impairing her decision-making abilities, she is temporarily incapacitated and cannot provide consent. The worker should assess for any needs requiring immediate attention (e.g., suicidality); otherwise, the worker should ask the member to return to meet the worker when she is not intoxicated.

Confidentiality

Respecting the dignity of people includes protecting their right to privacy, that is, ensuring they have control over their personal information. Social workers show respect for privacy by offering confidentiality, agreeing not to share personal information about a client unless the client provides consent (Standard 1.07(c)). Confidentiality is not an absolute right. Exceptions to confidentiality include release of information to safeguard the client or another identifiable person from serious, foreseeable, imminent harm (Standard 1.07(c)). In other words, social workers are ethically justified in overriding client confidentiality and consent if it is necessary to warn a potential victim or in taking other steps to protect the client or others from serious harm (Reamer, 2013).

State laws also require social workers to report reasonable suspicions of child abuse or neglect, as well as abuse or neglect of vulnerable elders or people with disabilities. Agency policies and contracts may also require certain types of disclosure; for instance, a group for perpetrators of intimate partner abuse referred by the criminal justice system may require the facilitator to report each member's attendance to his or her probation officer (Pollock, 2014). Under the principles of informed consent, group members need to be apprised of the nature of confidentiality and its limits at the outset of the group process. By providing clients with an opportunity to provide informed consent at the outset, members can determine whether they want to participate in the group, as well as what information they will share or not share within the group.

Groups vary in their purposes, structures, and composition. Hence the need for confidentiality also varies. Confidentiality may not be a significant issue in educational groups in which facilitators provide information and clients are not expected to share personal information. Likewise, in some task groups, members may not be concerned about whether their ideas or plans are shared with others. In a group designed to raise money for mental health awareness, for instance, group members may want the opposite of confidentiality—that is, broad sharing of information from the group. Conversely, in a therapy group in which members are expected to discuss sexual behaviors, HIV status, personal failings, or other potentially embarrassing information, members may desire very high levels of confidentiality protection. Some people, by nature, upbringing, or culture, may have greater sensitivities about privacy than others. Accordingly, workers need to address confidentiality in different ways with different groups.

Confidentiality within group work is not limited to the social worker's behavior; members also acquire information about each other and need to address how they will manage such information. The worker cannot guarantee that members will protect each other's privacy (Barsky, 2010). Respect for privacy and maintenance of confidentiality depends on the extent to which norms of confidentiality are developed within the group. Such norms ought to specify the nature, extent, and limits of confidentiality. Standard 1.07(f) advises group workers to:

seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in . . . group counseling that social workers cannot guarantee that all participants will honor such agreements.

Members need to decide what kind of information they will keep to themselves and what can be shared with family and friends, including information that may be shared electronically

through Facebook or other social media. Whether members are having positive or negative experiences within a group, they may want to share information about the group.

Workers can engage members in discussion about their expectations of confidentiality, including their concerns about the consequences of breaches of confidentiality; for instance, are they concerned about feeling embarrassed, losing a job, being shunned by family or friends, or getting in trouble with the law? Some groups may decide that they will not reveal any information about the group. Other groups may decide that members can share information about the group generally but must avoid any disclosure of information that could identify others in the group. Members could also discuss how to deal with situations in which they meet one another in public places: Will they acknowledge one another? Will they act as if they do not know one another? Or will they need to make different decisions depending on the context?

Maintaining confidentiality within rural and closely knit cultural communities may be particularly challenging, as everyone knows everyone (Humble, Lewis, Scott, & Herzog, 2013). Given that a key purpose of confidentiality is to encourage members to share thoughts and feelings, workers may also need to engage members in activities that promote cohesion and trust.

An important exception to confidentiality arises when a subpoena or court order requires a worker to testify or provide client records in a court proceeding (Borkosky, 2016). Workers need to understand that not all subpoenas are enforceable and that the client may have a right to *privilege*, that is, a legal protection for information learned in a confidential relationship, by which the court cannot compel a professional to testify. Privilege only exists for certain relationships as recognized by case law or by statute (Polowy, Morgan, Khan, & Gilbertson, 2011). Attorney–client privilege, recognized by case law, allows clients to consult with lawyers without fear that the lawyer may be called as a witness to testify against them. Some countries and many states have statutes recognizing privilege for licensed clinical social workers (*Jaffe v. Redmond*, 1996). Workers should consult their licensing legislation or talk to an attorney to determine whether their licensure is covered by privilege, and under what circumstances.

Legislation may also limit compellability of social workers and other professionals in particular agency settings, for instance, workers in addiction treatment programs or in shelters for abused clients (Barsky, 2012). One complication regarding privilege and clinical group work is whether or not the group would be considered confidential. Because information is being shared among group members, a court could find that the information is neither confidential nor privileged. From a legal perspective, to help protect confidentiality and privilege within group work, facilitators should:

- Establish the group as a closed group with a fixed number of members, rather than allowing new members to join or participate as the group progresses.
- Have each group member sign a confidentiality agreement stating that he or she understands that information shared in the group is to be kept confidential, as well as agreeing that he or she will not subpoena the worker or other group members to testify in current or potential court cases.
- Create a separate case file for each group member and avoid putting any information about other group members in each file.

Ultimately, courts retain the power to determine whether information shared in a particular group is privileged, so workers should inform members about this possible risk.

The use of online communication technologies to mediate group work poses various risks and challenges to confidentiality (National Association of Social Workers, 2016). Consider the use of videoconferencing. Although many videoconferencing programs include encryption and other safeguards, it may be possible for people to hack into a system and observe the group (Harris & Birnbaum, 2014). Furthermore, group members could save video or audio recordings and share them with friends or others outside the group.

One strategy to reduce these risks is maintaining anonymity among group members. Group counseling with avatars, for instance, allows members to use computer-generated figures and voices to represent themselves in the group's processes (Quackenbush & Krasner, 2012). The members could share identifying information with the facilitator in individual meetings but remain anonymous during group interactions (Harris & Birnbaum, 2014). As noted earlier, the degree of confidentiality protections for a particular group will depend on the needs of that group. Anonymity may be helpful for the initial stages of a coming-out group for gay and lesbian clients; for a group of clients who are already "out," anonymity may not be so essential.

THE IMPORTANCE OF HUMAN RELATIONSHIPS

The social work value for *human relationships* is derived from the belief that individuals are inherently social beings, connected to one another and interdependent for survival and fulfillment of their needs. At its core, group work embraces and builds on human relationships. As the NASW Code (2008) states:

Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

As group members interact, they both influence and are influenced by each other. The worker is responsible for helping members to develop patterns of communication and norms of behavior that foster mutual aid (IASWG, 2010; Zastrow, 2015). Thus workers should engage members in discussions of group guidelines that promote positive interactions, for instance:

- **Democracy and voice:** All members have an opportunity to express their views and participate in group decision making (Lindeman, 1939).
- **Interdependence:** Members have a responsibility toward each other, including duties to listen, attend to each other's concerns, and follow through on commitments (including attendance, participation, and commitments to keep certain information confidential).
- **Diversity:** Members will demonstrate respect for one another regardless of similarities or differences in culture, ethnicity, race, sex, gender identity and expression, sexual orientation, ability, belief systems, political affiliations, or other aspects of human diversity. Members will avoid judging or speaking for others.
- **Strengths:** Members will build on the strengths of each individual, and the group as a whole.

Rather than imposing rules on a group, facilitators can empower members and foster ownership of group guidelines by having the group develop and build consensus around guidelines that meet the specific needs and purposes of the group (Toseland & Rivas, 2017). These guidelines act as the group's code of ethics or expectations for how members will relate to one another. These guidelines also serve as a contract between the worker and members, articulating their mutual commitment and responsibilities. Building consensus and contracting provide the group with processes for informed consent, clarifying ethical issues and accountability, and empowering members to make self-determined choices.

Boundaries are invisible lines of demarcation that determine the extent of separation and connection between individuals or social systems, including families and groups (Hepworth et al., 2013). Boundaries define relations in all spheres of human interaction: physical, psychological, social, and spiritual. Social workers need to establish appropriate professional boundaries with clients, avoiding dual relationships that pose risk of exploitation (Standard 1.06(c)), avoiding sexual contact of any kind (Standard 1.09), and avoiding physical contact that may put clients at risk of psychological harm (Standard 1.10). A dual relationship arises, for instance, if a social worker facilitates an addictions group at a treatment center and then invites members to participate in a particular Alcoholics Anonymous self-help meeting with him.

What constitutes appropriate professional boundaries depends on the context, including the nature and purpose of the group, the model of intervention being used, and the cultures of the members within the group. In a therapy group for survivors of sexual abuse, the facilitator might need to be particularly careful about respecting personal space and physical boundaries of the clients. Hugging clients may be inappropriate in this context, given the psychological risk to clients. In contrast, hugging may be appropriate as a good-bye gesture for clients in a healthy lifestyles educational group, particularly if the clients invite a hug and the worker assesses the psychological risks as minimal. Even though social workers should avoid imposing religious beliefs on clients, it may be appropriate for a worker to share her or his religious beliefs in a group that is specifically geared toward that religion.

A *boundary crossing* is a situation in which a professional interacts in a way that is not within the usual parameters of the professional relationship (Gutheil & Brodsky, 2008); for instance, a social worker offers a group member a coat to wear home because it is very cold. Boundary crossings can help clients; however, they may also pose risks. Boundary crossings become *boundary violations* if they result in negative consequences for the client; for instance, if the client who receives the coat develops a romantic attraction to the worker, or if the worker asks the client for a favor in return and the client feels exploited. Maintaining firm boundaries is generally safer in terms of avoiding allegations of exploitation or malpractice. Given that social work is a profession based on caring and helping, however, social workers should avoid being too rigid or distant in setting boundaries with clients. Reaching out and interacting with group members are important aspects of group trust and development.

Whereas the NASW Code describes appropriate boundaries between workers and clients, it does not govern boundaries between clients within a group. Workers and group members need to determine appropriate boundaries, including whether it is appropriate for group members to contact each other outside of the group, whether they may date or have sexual relations, and whether they may discuss issues that are the focus of the group (Barsky, 2010).

For support groups, it may be particularly helpful for group members to maintain relationships outside of the group, providing them with access to support on an ongoing

basis. For other groups, the worker and members will have to balance the potential benefits and risks of interactions outside of the group. Consider a families-in-transition group for parents going through divorce processes. What should a worker do if the group wants to share telephone numbers and email addresses so they may contact each other outside of the group, but the worker knows that a particular member has a history of intimate partner abuse, including stalking? How should the worker balance the interests of client safety, self-determination, informed consent, and confidentiality?

INTEGRITY

Social workers hold themselves to a high standard of *integrity* (Standard 5.01(a)) given their *fiduciary relationship* with clients; that is, because social workers work with vulnerable populations (including children, frail elders, and people with mental illness), workers owe them a special duty of care. Although some people equate integrity with honesty, integrity also includes reliability and responsibility. By acting in an open, honest, reliable, and responsible manner, social workers ensure that the interests of clients are met, protecting them from exploitation and substandard practices (Barsky, 2010).

Within group work, honesty and openness are crucial in the development of effective worker–member relationships. Withholding important information from the group creates difficulties in communication. It is unethical for workers to participate in dishonesty, deceit, and fraud (Standard 4.04). A frequent example concerns the lack of honesty in informing members about the agency’s purpose for the group. For instance, a group to remediate bullying among students who have participated in bullying may be given an innocuous name such as the “Blue and White Club,” with a stated purpose of “providing interesting and enjoyable after-school activities.” Social workers may not intend to deceive, but they may fail to present clearly the purpose for which the group was formed. They may be fearful of negative responses or that prospective members will decide not to join the group. When workers frankly present the hoped-for outcomes and the means for achieving them, members often are relieved, and their interest in the group is enhanced (Kurland & Salmon, 1998). When there is disparity between the stated and hidden purposes, trust is violated. Sneaking in a different purpose is incongruent with the core conditions for therapeutic alliances: unconditional positive regard, empathy, and genuineness. “If the practitioner cannot say it to clients, then the practitioner has no right to try to do it” (Northern & Kurland, 2001, p. 179).

Honesty between group members may also present certain challenges. Some members may not be ready to discuss certain aspects of themselves due to shyness, embarrassment, or cultural norms against sharing personal problems with people outside their families or communities. From a psychodynamic perspective, clients may use denial, minimization, rationalization, avoidance, and other defense mechanisms to ward off anxiety, protecting their egos or positive self-images (Metzger, 2014). Facilitators can foster honesty among group members by using various strategies to build cohesion and trust:

- Developing group guidelines pertaining to confidentiality, respect, and making the group a safe place to be open and honest
- Encouraging the sharing of personal information related to the group’s purpose
- Engaging in activities in which members learn to work together and depend on each other

- Helping members work through conflicts in a respectful, collaborative manner
- Modeling honesty and trustworthiness (Toseland & Rivas, 2017; Zastrow, 2015)

A group facilitator is not responsible for verifying the truth of every client assertion, nor is the facilitator responsible for correcting every piece of misinformation provided. Rather, the facilitator fosters conditions within the group that enable members to be more open and honest. When a member alleges dishonesty or lack of full disclosure by another member, the facilitator helps them process this conflict in a respectful manner.

Within some groups, members are discouraged from challenging the veracity of what others say, with each member taking responsibility for what he or she says. An ethically challenging situation arises when a member makes a false statement that the facilitator knows is false, and the facilitator has to balance the rights of the individual member with the rights of the rest of the group. Consider a member who informs the group that he has Lou Gehrig's disease, a condition that causes muscle wasting and has no cure. The worker believes he is pretending to have this disease to elicit sympathy from other members. Although the facilitator wants to encourage honesty within the group, she also has to be careful not to breach client confidentiality or self-determination. The facilitator could meet the member individually, but what are the facilitator's duties if the member persists in saying he has the disease? Furthermore, what if the member is not trying to be dishonest but has a mistaken belief due to schizophrenia and auditory hallucinations telling him he has the disease?

PROFESSIONAL COMPETENCE

Professional competence refers to having the knowledge, values, and skills required to provide particular services in an effective manner. Being acquainted with theory is not enough. The theory must be transformed into action through the use of specific skills, such as facilitation, active listening, and conflict management skills. Clients have a right to competent help so that the services they receive are, indeed, likely to be helpful (Reamer, 2013). As Standard 1.04 provides, social workers should provide services "only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience." Social workers are ethically and legally accountable for what they do, the way they do it, and the results (Reamer, 2013). Practicing outside one's area of competence puts clients at risk of harm. It also places the worker at risk of malpractice lawsuits, as well as agency-based discipline, professional review, and potential revocation of licensure to practice.

The IASWG (2010) practice standards identify specific knowledge and competencies for social workers in relation to various stages of the group process. An important aspect of competence is being able to research and understand the evidence base of alternate models of intervention relevant to the work that one is doing. Group workers need to be familiar with current theories, models, and research on group work practices relevant to the client populations and biopsychosocial concerns they are managing (Macgowan & Hanbridge, 2014). Consider a worker planning to offer a "moderate use" group for people who have problems with alcohol. Which specific group interventions is the worker contemplating? What does the research say about the relative effectiveness of these interventions? What are the potential risks? What knowledge and skills are needed for the worker to effectively implement these interventions?

The use of any model of practice needs to be appropriate to the cultural diversity, problems, and strengths of prospective members. As standard 1.05(b) provides:

Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

Culturally competent practitioners are aware of their own personal and cultural values, including ways these are similar to or different from those of their clients, those espoused by the agency that employs them, and those expressed by dominant segments of the community. They are able to respond respectfully to people of varied races, religions, ethnic backgrounds, genders, sexual orientations, and socioeconomic statuses (Lum, 2011). Social workers need to respect diversity and individuality while simultaneously attending to what clients have in common.

Understanding both shared and disparate values, norms, traditions, language, history, and beliefs enhances respect for diversity. "Unity in diversity" was a core theme in the philosophy of one of the profession's great founders, Jane Addams.

ETHICAL DILEMMAS

Often, social work articles on ethical dilemmas describe them as difficult or challenging situations. Given that the worker may be faced with conflicting ethical obligations and no clear option that satisfies every obligation and every stakeholder's interests, ethical dilemmas can be challenging. Ethical dilemmas are also exciting opportunities to advance group bonding, respect for diversity, client growth, social justice, and problem solving. Although some ethics textbooks suggest an individual decision-making model for ethical decision making, a collaborative and process-oriented approach is more appropriate for social work with groups (Barsky, 2014). After all, group work is a method of working with collections of people for personal growth, enhancement of social functioning, and achievement of socially desirable goals (IASWG, 2010). Rather than a social worker thinking through the ethical issues on his or her own, the social worker engages group members and other stakeholders in a joint problem-solving process. The stages of the process for managing ethical issues are: (1) identifying ethical issues, (2) determining appropriate help, (3) thinking critically, (4) managing conflict, (5) planning and implementing decisions, and (6) evaluating and following up (Barsky, 2010). To illustrate how this framework can be incorporated in social work with groups, consider the following situation:

Fran facilitates a coming-out group for lesbian youth (15–17 years old). Because these youth live in rural and remote communities, the group is conducted online through the use of avatars. Members remain anonymous and protect their privacy by using pseudonyms and not sharing identifying information. During one session, three members—Lynda, Yvonne, and Cheryl—disclose that they have been receiving emails with antigay messages and threats to "out" them to classmates at their schools. They are concerned that someone has infiltrated the online group and is using information from the sessions to terrorize them. Lynda thinks the group should be terminated. Yvonne and Cheryl say that the group is too valuable and that they do not have any other options for support in their communities. Fran, who has gone to great lengths

to create a safe haven for these youth, is shocked, troubled, and uncertain about how to proceed.

Identifying Ethical Issues

To identify the ethical issues, the facilitator engages the group in a discussion of what has happened and what ethical concerns need to be addressed. Although Fran may have her own ideas about the nature of the ethical issues in this case, it is useful for the group to take ownership of how they will deal with the dilemma, including how the ethical issues are defined. Initially, some group members are concerned that their privacy has been violated and that they are being harassed as a result. They want the harassment to stop. Other members are concerned about whether the group can and should continue. Fran validates all their concerns and helps them articulate the ethical issues more clearly. They eventually decide that the most pressing issue is, "Should we end the group, or is there a way to continue the group and still make sure that everyone's privacy and safety is protected?" Some group members want the group to be terminated immediately; others want the group to continue. Fran suggests that they explore the issues further before making such decisions. She also invites the group to identify any relevant information that is unknown or uncertain. Yvonne notes that they do not know whether the person initiating the harassment is in the group or who that person might be. Group members decide that their discussions at this point will focus on resolving the ethical issues. They decide that if any member wants counseling or support, she will contact Fran on a one-to-one basis. They will not process such issues in the group until the ethical concerns have been resolved.

Determining Appropriate Help

In this stage, the facilitator works with the group to identify potential sources of support. Fran asks group members whom they might consult to help them deal with the ethical issues. Lynda suggests that Fran contact the information technology (IT) specialist who helped set up the avatar program to determine whether anyone has hacked into the system and to determine what other safety precautions could be included. Cheryl asks whether they need to inform their parents about the safety or privacy issues. The group decides to allow group members to make their own decisions, depending on the seriousness of their concerns and how comfortable they feel talking with their parents. Fran informs the group that she needs to consult with her supervisor and risk management officer for her agency. With the group's consent, Fran consults with the IT specialist, supervisor, and risk management officer. The IT specialist is unable to identify any breaches or weaknesses in the security of the system. He suggests that group members change their passwords and offers advice on how to develop stronger passwords. The risk management officer suggests that the group should be terminated immediately so that no further risks are incurred. The supervisor notes that it is important that Fran continue the group so as not to abandon members, particularly as some may need additional support due to the harassment and threats of outing. They agree that Fran should contact each member individually to offer support and to allow them to determine whether the group should continue to operate. Various members express different views on this matter. Cheryl notes that the principle of autonomy allows people to have different views and although it would be ideal for everyone in the group to reach consensus on how to proceed, it may be OK if different people make different decisions. The group then discusses the values of group consensus versus individual decision making.

Thinking Critically

To help the group use critical thinking, the facilitator can help group members explore the ethical issues in relation to their goals, options, consequences, ethical principles, agency policy, and relevant laws. When Fran asks the group about their *goals* for managing the ethical issues, they build consensus around the following: (1) protecting members from being “outed” without their permission, (2) protecting members from harassment, (3) providing members with a safer place to deal with their coming-out concerns, and (4) holding people accountable for violating their rights to privacy and to be treated with respect. Fran then engages the group in brainstorming to identify options that could help them achieve these goals. They generate a comprehensive list of options, including asking the police to investigate, terminating the group, having a face-to-face group rather than an online group, having a teleconferenced group rather than avatars, having one-to-one sessions with Fran, and having Fran meet separately with each group member to assess whether it is safe for that person to be in the group.

Fran then turns the group’s attention to ethical principles such as beneficence (doing good), nonmaleficence (doing no harm), justice (fairness), and autonomy (freedom from coercion; Barsky, 2010). After explaining these principles, Fran invites the group to discuss how they may apply in this situation. Cheryl suggests that beneficence refers to the purpose of the group, providing group members with emotional and social support. Lynda says there may be an issue with nonmaleficence because the group exposes them to having their privacy breached. She questions whether being in the group is more beneficial or more risky.

Fran also informs the group about agency policy and relevant laws. For instance, she describes the agency’s policies on informed consent. She notes the agency did inform group members and their parents that, although precautions would be taken to ensure protection of their privacy, there was a possibility that the system could be hacked, and privacy could not be 100% assured. She also reminds the group about its own privacy agreement, that members in the group promised not to share information outside the group. As discussion progresses, a split in the group becomes more apparent. Some members believe that their trust has been breached and the group must be ended. Others believe the group needs to continue, as otherwise they would lose their primary source of support. Tempers flare when Lynda suggests that the person harassing her was probably Cheryl. Cheryl flatly denies this allegation as outrageous.

Managing Conflict

Although some people view conflict as bad and prefer to avoid it, facilitators know that conflict is a natural part of group processes, particularly when ethical issues arise. Group facilitators may use a range of conflict management skills, including reframing, deemphasizing blame, focusing on the future, identifying common ground, negotiating, and helping group members listen to and validate each other’s perspectives, regardless of whether they are in agreement (Barsky, 2017). In the present situation, some members are stuck on the breach of their confidentiality. They want the person who violated their confidentiality to be punished.

When Fran asks the group to consider what can be done now, in order to move forward, the group notes that there is not much they can do to hold the violator accountable. They have already agreed that individual members can decide to report their concerns to the

police, but most members do not think the police can do much. Focusing on the future, the group notes that safeguarding anonymity is key.

During further brainstorming, Yvonne notes that they have been using their email addresses to log onto the avatar group. The group decides that it would be safer to have unique user names that do not link members to their email addresses, actual names, or other identifying information. They also note that members may wish to close down their original email accounts and open new ones, preventing the person who sent harassing emails from sending further emails. Most members decide to continue in the group. Lynda decides not to participate in the group, but she will work with Fran on a one-to-one basis. Everyone acknowledges that each person has a right to make her own decision.

Planning and Implementing Decisions

As Fran implements the decisions, she works with the IT specialist to set up new user names and passwords for clients that cannot be used to link them to their email addresses or other identifying information. Fran calls each member once a week for the next 3 weeks to determine whether there are any other concerns about breach of confidentiality. Fran also works with her supervisor and risk management officer, as originally the risk management officer wanted to terminate the group. With the added protections and informed consent of the parties, the supervisor and risk management officer support continuation of the group.

Evaluating and Following Up

When Fran contacts each group member, she enquires about any further harassment or concerns about confidentiality. Fran documents no further concerns and reports this information back to her supervisor and risk management. Fran also tracks whether various members have reported the harassment to the police and any actions taken by the police. Finally, Fran follows up with Lynda, providing one-to-one counseling and evaluating whether Lynda would like any further support or referrals. Group members eventually agree no further follow-up is needed.

As the foregoing case illustrates, the group can be a powerful resource for analyzing and managing ethical dilemmas. Although group work may present unique challenges in relation to conflicting values, informed consent, appropriate boundaries, confidentiality, and other ethical issues, employing a collaborative process to engage and empower group members can help in developing effective solutions on the basis of group involvement and consensus.

NOTES

1. Helen Northen, who passed away in 2006, was the sole author of this chapter for the first edition of this book. Her family is pleased that Helen's memory and contributions are honored by maintaining her name as a coauthor with Allan Barsky, who has made substantial revisions and updates to this chapter.
2. Deontologists study ethics from the perspective of duties. Deontologists determine ethical behaviors by analyzing which ethical duties should be followed. Ethical decision making is guided by the rightness of the act, regardless of the consequences.
3. Unless otherwise indicated, references to "Standards" in this chapter refer to standards in the NASW Code of Ethics (2008).

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CHAPTER 6

Group Work and Socially Just Practice

R. M. ORTEGA

Social work's commitment to social and economic justice is particularly relevant at a time when landmark Supreme Court rulings and social activism across the country promote equal and inclusive marriage opportunities regardless of sexual orientation, affordable health care for low-income individuals and families, equal law enforcement protection without the use of excessive force against racial and ethnic minority individuals, and other remedies against prevailing forms of social injustice such as persistent economic inequality and disparities in resource access and allocation, hate speech, ethnic intimidation, forced gender segregation, and disabilities and aging discrimination.

Current theories about social justice and forms of injustice in group work practice reflect upon overt and covert barriers to justice that become reenacted or sustained in small-group interactions in the form of micro aggressions, the imposition of unearned privilege, and other means of oppression that endure in society (Acker, 2006; Martin, 2004; Ridgeway, 2006; Rowe, 1990; Schippers, 2008).

Through small groups, promoting social justice practice coincides with our understanding of the complex interpersonal interactions, social structures, processes, cultural mechanisms, and leadership that sustain a group's stability, identity, belongingness, meaning, and effectiveness (Garvin & Ortega, 2016; Reed, Ortega, & Garvin, 2010). Ignoring mechanisms and processes of injustice in small groups, for example, has the potential to privilege certain members. And by failing to reflect upon and confront the dynamics that contribute to the marginalization and oppression of "nonprivileged" group members, we ignore the emergent disempowering conditions that perhaps led to their reliance on the groups' input for guidance.

Members of the newly built affordable housing complex met each month at the request of an assigned community organizer. Residents talked about how to keep their neighborhood safe, especially for their children, since there was constant entry and exit of residents and relationship partners. Their frustration grew when crises calls to police were met with delayed responses, "victim-blaming," and superficial investigations. Recently, a life-threatening assault occurred against one of the children by a visiting adult and only then was attention drawn to the safety concerns the residents tried to impress upon the police.

During the first 20 minutes of this evening's meeting there was inconsolable anger directed toward the visiting police officer.

From a social justice perspective, members enter the group in possession of their own positionalities, standpoints, and epistemic privilege. Positionality refers to one's social positions in relation to others with whom one is in contact and the extent to which these positions influence aspects of the relations or perceptions about the others. Those who occupy different positionalities develop different knowledge and worldviews (*standpoints*) informed by their social locations (Maher & Tetreault, 1993; Takacs, 1993).

The phrase *epistemic privilege* focuses on the more immediate, subtle, and critical knowledge of one's oppression and the affective experience of this oppression outside the awareness of nonoppressed members (Narayan, 1999). Members enact patterns from the larger society, and it may take considerable effort to sort out individual factors affecting group members' behavior from those reflecting larger forces in the current situation. Personal change, then, requires an appreciation of the societal and cultural contexts in which members are embedded. Also, the experiences of members should be examined from within their historical context. Recognizing and harnessing these different views and sources of knowledge are critical for incorporating social justice values and approaches into small groups (Reed et al., 2010).

WORKING WITH CONFLICT AND POWER

A social justice perspective in groups moves us beyond binary comparisons. In this way, we become knowledgeable about important shared characteristics within a group, yet remain attentive to the multiple differences in identities and experiences reflected in each member. And whenever members of different social experiences and perspectives interact, there is an increased likelihood of conflict. Conflict is an important component in the knowledge and theory of social justice group work for at least three reasons. First, it may reflect the consequence of coming together across organizational interfaces or social group boundaries that have otherwise maintained separation and distance. Histories of distrust and social power differences, as is often the case when a racial or ethnic-minority group member who has experienced disparities interacts with a majority group member, often lead to conflict that may be difficult to reconcile (Garvin & Ortega, 2016; Reed et al., 2010).

Group member incompatibility or variance is also likely to surface as a result of a divergence of strong opinions or interests, or struggles for status, power, and authority. Conflict under such circumstances, when left unchecked, can increase dislike and distrust among members. In fact, some of the most difficult conflicts to negotiate are those that occur around the "fault lines" in which differences are polarized and associated with patterns of distrust and power and/or when multiple types of differences coincide (Homan, van Knippenberg, Van Kleef, & De Dreu, 2007). Fault lines occur when subgroup categorizations or emerging power and status differentials influence or disrupt group processes. An example is decision making that uses criteria other than the best knowledge and skills about how best to proceed.

Finally, conflict in small-group practice is more traditionally recognized as a component in group development and maintenance. Conflict can be a positive, negative, or neutral force in small groups, but all types of conflict are important within and between groups, especially in working with groups to reach desired social justice goals (Brown, 1983; Reed et al., 2010). Conflict, from the group's initial development, has been described as the unavoidable, necessary, and important phase during which norms, procedures, and member roles and rankings are established (Forsyth, 2010).

Different types and severities of conflict may require different approaches. Within these groups, facilitation must attend to emotional, cognitive, and behavioral issues and triggers so that group members can develop more positive feelings and thoughts about people who represent other social categories and some skills for communicating and working together across differences (Stephan, 2008).

POWER AND SOCIAL JUSTICE IN GROUPS

Power is often defined as the influence and resources needed to accomplish desired goals. Power in groups is typically recognized as sources of control and authority over processes and outcomes, including decision making, leadership, mechanisms of social control, and so on (Forsyth, 2010). Although not everyone seeks social power, nor is power automatically assumed to be power over others (e.g., some may seek personal power), the point is that power in groups exists within the context of member relationships. Socially unjust power privileges and enhances certain members and imposes influence over others, devaluing and disregarding their worth.

The Latino/a social work group opened up their new student orientation meeting by sharing with incoming Latino/a students their concerns about being marginalized and relatively voiceless in the school. Several students shared how frustrated they became after class discussions that seemed to foster stereotypes and prejudices, especially about undocumented immigrant families and the profession's uncertain role in advocating for their services. While most students remained silent, one incoming student asserted she worked for a welfare rights organization prior to returning to school and learned how to be a strong advocate for all families. She stated she often had to force attention to get her service users what they needed. She wanted to do the same at the school. The second year students urged her and others to learn more about what they had done to strengthen their visibility and willingness to work collaboratively with the school administration in order to develop improved relationships and positive visibility.

Power, sources of power (e.g., French & Raven, 1960), power dynamics and effects of power in terms of enhancement and inhibition are critical aspects to consider in social justice group work practice. Harnessing power is necessary to promote change and work for social justice. Feminist scholars and activists, for example, urge those concerned about creating change for social justice to strive to use collaborative forms of power—having power *with* others by working together—versus using power to dominate or control others (e.g., Townsend, Zapata, Rowlands, Alberti, & Mercado, 1999).¹ Research emphasizes the importance of continuously assessing the extent to which views and values are represented in the group's activities and decisions and identifying some of the ways that group members may be recreating oppressive and marginalizing power differences among themselves. Attending to the entire group network is important in group work, as everyone is involved in sustaining these forms of power and disrupting and becoming aware of forms of socially unjust forms of power is difficult and requires regular and ongoing collective reflection (Reed et al., 2010).

There is increasing knowledge about how different types and sources of power combine to contribute to the development and maintenance of privilege and oppression. Privilege is defined as unearned advantages, for example, that are associated with social categories that have higher status in society (e.g., whiteness, masculinity, higher economic class, heterosexuality, membership in a dominant religion) (Goodman, 2001; Johnson, 2001). McIntosh (1988/2000) defines at least two types of privilege: those that are desired states that should be accorded to everyone, and those that disadvantage certain others.

TABLE 6.1. Functions of Different Types of Groups

Benefits and purposes of groups	Examples
Groups help shape personal identity, feelings of belongingness, a sense of meaning and purpose.	Families, peer groups, affinity groups (share a common interest or value), ethnic groups, some neighborhoods
Groups help to socialize people (i.e., to learn societal or organizational norms and customs and decide on and fulfill new roles).	Peer groups, affinity groups, families, educational groups
Groups help people to change and grow and can support them through difficult times.	Mutual aid groups, support groups, therapeutic or psychoeducational groups
Groups can facilitate planning, decision making, and problem solving in many settings (for policy, in organizations and communities); groups are vehicles for getting work done.	Work groups and teams (in communities, organizations and government), task forces, boards of directors, committees, town hall meetings, volunteer groups (e.g., parent–teacher organizations), advisory groups
Groups can be vehicles for those with varying degrees of power to join together, plan, stimulate and guide social change (including challenging injustice and working for justice).	Groups for social planning and social action, political advocacy groups, neighborhood advocacy groups
Groups can have memberships that cross organizational and group boundaries to coordinate goals, activities, and services in complex environments.	Multidisciplinary and professional teams, steering committees, community coalitions, and collaboratives
Groups can be used to help people learn about their social categories, communication, privilege, oppression, and what is needed to work for justice.	Groups for consciousness raising and dialogue; groups as part of diversity training and/or that allow people to negotiate differences

Oppression refers to the ways that people experience barriers to participation in society, such as exercising their rights and taking advantage of opportunities. Mechanisms that form and sustain oppression are multiple and are often not recognized even by those affected by them. Young (1990) classifies five types of oppression: powerlessness, marginalization, exploitation, cultural hegemony, and violence. People can have multiple responses to their own experiences with oppression (Mullaly, 2007). Some internalize their oppression and experience lower self-esteem and efficacy as a result. Others actively resist oppressive forces, often in concert with others.

UNDERLYING VALUES ORIENTATIONS FOR SOCIAL JUSTICE GROUP WORK

The ethical obligations that social workers in groups abide by are no less important than they are in any other form of practice. In group work, members' dignity and worth is valued, as are their uniqueness and individuality. Group members are viewed as capable of growth and change and should be supported in increasing their choices in solving their problems and directing their lives. And finally, each member of the group deserves access to the resources they need to deal with life's problems and to develop their potentialities (NASW Code of Ethics, www.socialworkers.org/pubs/code/code.asp).

Working with and building on differences in social work practice in groups must draw attention to important values that orient a social justice perspective. Solidarity, tolerance, inclusion, trust, cultural humility, empowerment, and shared leadership (i.e., reflecting the acronym *STITCHES*) must be viewed as important threads woven into the fabric of group work practice. The metaphor of *STITCHES* is intentional since the presence of injustices is argued to contribute to fractures or tears in the group's ability to work together and accomplish its goals within the group and between the group and the outside world.

Solidarity

Social justice work focuses on the underlying values and beliefs that comprise a core set of principles used to guide socially just practice within groups and between the group and the outside world (Breton, 2011). Social justice, for example, calls for *solidarity*, or unity arising from mutual support, and recognition of common ground, common responsibilities and shared interests between members of different classes, cultural experiences (including linguistic differences), identity groups, and so on.

Tolerance

Social justice group work practice requires *tolerance*, evidenced by a fair, objective, and open attitude toward those whose opinions, beliefs, practices, racial or ethnic origins, or preferences differ from one's own. Building on the previous focus on conflict, tolerance suggests that disagreements are anticipated. Tolerance does not preclude the right to reject someone's claims or beliefs but rather works with expressions of opposing ideas, opinions, and practices from one's own by demonstrating patience and open-mindedness.

Inclusion

Social justice group work practice is *inclusive* to the extent that it offers an active, intentional, and ongoing effort to invite, admit, engage with, represent, affirm, and integrate all diverse members and their interests as important aspects of group membership. Differences that emerge become part of the group's developmental processes and activities.

Trust

Social justice group work requires *trust*. When working with disempowered and marginalized populations, movement in groups toward any desirable change is unlikely to proceed without establishing some degree of trust among members, between members and group workers, and between the group and organization affiliations, especially if that affiliation is distrusted within the members' communities (Yoshihama & Carr, 2003).

Cultural Humility

Because members of groups represent a microcosm of the world's cultural diversity, they also transfer the potential cultural tensions and conscious and unconscious biases that arise when a variety of groups come together from different backgrounds, cultures and experiences. Key cultural lessons require: (1) awareness of privilege in light of members' plights; (2) members as teachers; (3) awareness of members' perceptions of worker; (4) meeting members' emotional needs with empathy; and (5) concern for members' integration into community (Reed et al., 2010).

The starting point for a culturally responsive approach is to consider one's assumptions and beliefs embedded in one's own understandings and goals in the group encounter. Cultural responsiveness calls for an attitude of openness to receiving new information and new perspectives on a regular basis. It calls for demonstrating *cultural humility* (Ortega & Faller, 2011), which emphasizes two important concepts as important threads that weave together critical aspects of social justice work. First, it acknowledges the complex interaction of our multiple identities (*intersectionality*), including the social consequences and privileges afforded by our differences. The intersectionality or autonomic integration of our multiple social identities raises our complexity to a level that may seem difficult to understand, yet can provide opportunities to look for both similarities and differences among members and take multiple elements of someone's positionalities into account (Brown & Mistry, 1994; Pyke & Johnson, 2003; Reed et al., 2010). And since people can simultaneously occupy positions that are associated with higher or lower status (power and resources) within society, very few will experience oppression or benefit from unearned advantage (privilege) in *all* aspects of our social identities (Craig & Rand, 1998).

Multiculturalism, in addition, emphasizes how individuals may change along identity dimensions depending on the degree of support for and retention of one's multicultural self and involvement in the new societies that may shape and reshape core aspects of one's self (Cohen, 2009; Ivey & Collins, 2003; Hook, Davis, Owen, Worthington, & Utsey, 2013; Sengupta, 2006; Tervalon & Murray-Garcia, 1998).

Empowerment

Social justice in groups supports mastery and control that members gain over their lives. Through *empowerment*, members become active participants in efforts to influence their environment (Breton, 2004; Mullender, Ward, & Fleming, 2013). The earlier discussion of power and the multiple forms of power recognizes meanings beyond (although inclusive of) domination, authority, and control. Three components of *empowerment*—as social, multidimensional, and process—are basic to any understanding of empowerment in groups. Empowerment, by definition, is social as it occurs in relationship to others. Empowerment, by definition, is social since it occurs in relationship to others. Empowerment is multidimensional in that it occurs within sociological, psychological, economic, and other dimensions and also occurs at various levels, such as individual, group, and in interaction with community. Empowerment is a process similar to a path or journey, one that develops as members engage in the group's work through collaborations based on mutual respect, diverse perspectives, shared reflections, and a collective developmental vision (Breton, 2004; Florin & Wandersman, 1990; Mullender et al., 2013; Speer & Hughey, 1995).

An important implication of this perspective on empowerment is that the individual, group, and community are essentially interconnected. Within a group, empowerment involves building trust, cooperation, and communication between members, and a prerequisite for this aspect is that there are appropriate structures, protocols, and procedures in place, with effective sanctions against those who default or abuse the power afforded within the group.

Shared Leadership

The final values orientation in social justice group work focuses on shared leadership. Shared leadership has been defined in a number of ways, but all definitions include a process

of influence that relies on a broad sharing of power and influence among a set of individuals rather than centralizing it in the hands of a single individual acting in the clear role of a dominant superior (Pearce, Manz, & Sims, 2009). Shared leadership relies on three dimensions: shared purpose, social support, and voice (Carson, Tesluk, & Marrone, 2007). Shared purpose is evident when team members have similar understandings of their group's purpose and take steps to ensure a focus on collective goals. Social support refers to the extent to which group members actively provide emotional and psychological strength to one another. This may occur through overt acts of encouragement or expressed recognition of each other's contributions and accomplishments. Voice is the degree to which group members have input into how the group carries out its purpose.

DIMENSIONS OF GROUP WORK FOR SOCIAL JUSTICE

Four major dimensions are considered important for linking diversity and social justice to group concepts, performance, and outcomes (Garvin & Ortega, 2016). These dimensions relate to the following: (1) group purpose and activities, (2) group dynamics, (3) group development and process, and (4) group leadership. Key components of small groups within these dimensions are discussed from a social justice viewpoint to clarify their contribution to furthering the inclusion of social justice as an essential aspect of group work effectiveness.

Group Purpose and Activities

In their transitions group, several male prisoners who were ending their prison sentence met to talk about and support each other. The worker hoped to focus on important tasks such as maintaining contact with their assigned parole officer, connecting with transitional housing, finding employment, and so on. Several members expressed doubts about "surviving in the real world." They were convinced nobody would hire them knowing they had served time in prison. At least one member openly indicated he would have a hard time because he was going back to the same neighborhood where he got into trouble. He worried he would fall back in with his old "friends." As a whole, the group members talked openly about the survival skills they learned for prison life and wondered how long it would take for them to adjust to life outside the prison.

The group's purpose is likely to be influenced by the knowledge and perspectives that group members obtain from the larger environment. For example, group members will bring to their performance of tasks assumptions about social justice that are influenced by societal values and approaches to justice. These may include definitions of human well-being, values about the human condition, rights, and responsibilities, and assumptions about conflict and community (Reed et al., 2010). Similarly, societal beliefs and values, key symbols, rituals, and ideals influence what members value and define as acceptable and how they understand and draw meaning from their lives and interactions.

Group Dynamics

In this section, important aspects of group dynamics are bounded around four main dimensions similar to those of Toseland and Rivas (2005)—interaction and communication, cohesion, social structure, and group culture. This discussion is undertaken with the perspective that a group must be viewed as a complex social system, containing aspects of all these

dimensions as reflecting powerful forces that significantly shape member actions (Forsyth, 2010). All groups are embedded in a social and environmental context, and, as indicated below, represent clear opportunities to uncover subtle and obvious forms of social injustice while also affording opportunities to build on socially just practices in the context of group dynamics analyses.

Communication and Interactions

Early on in a church youth group, members became clearly annoyed whenever Marco spoke. While Marco didn't usually have much to say, when he did try he often stuttered and took long pauses between words. His speech difficulties tested the patience of the other members and were met with gestures of "Oh no!" and "Not this again!" by other members. Marco did, however, have a wonderful singing voice, which captivated listeners since he seamlessly sang with no evidence of any speech or thought challenges. The worker engaged the group in musical activities that brought out Marco's talents (and also exposed other members' musical limitations!). The group was able to see how dismissive their communication and interactions were and developed a greater appreciation of Marco as a person. In their discussions, members were also able to see how harmful their verbal and nonverbal behaviors were to Marco.

As previously discussed, becoming aware of and building on group members' multiple positionalities and standpoints is especially important in the various ways members interact and communicate. Groups provide opportunities for learning yet may present barriers to social justice when oppressive verbal and nonverbal exchanges are not recognized or called out. Considerable knowledge now exists about different ways of knowing and learning and how people respond to novel social contexts depending on their backgrounds and cultural styles (e.g., Goodman, 2001). Opportunities to share relevant histories and experiences can help members learn to interpret each other's behaviors and support each other. To achieve this requires bringing to the fore stereotyped expressions about racial and ethnic groups, such as being culturally monolithic. It means challenging the deeper meaning of stereotypes and potential for discrimination and the resulting marginalization and other harms that stereotypes engender (Garvin & Ortega, 2016; Reed et al., 2010). Group members who have experienced marginality and historical trauma may be distrustful of or impatient for change. Professional wisdom consistently asserts how important it is to assist everyone to examine how they have internalized oppression and to learn skills for individual and group empowerment, consciousness raising, increasing group connections, and relationship building across differences and taking action through advocacy with others (Burnes & Ross, 2010; Ratts, Anthony, & Santos, 2010; Smith & Shin, 2008).

Cohesion

Cohesion is a critical aspect when conceptualizing a group's dynamics, as it can only come about once a group exists (Forsyth, 2010). Cohesiveness, typically defined as all forces acting on members to remain in the group (Festinger, 1950) or, more narrowly, how much members are attracted to a group, is an important element for building and sustaining a viable group. Early research on similarity and attraction in groups and theories related to social identification and social facilitation focused on the value of homogeneity in increasing cohesiveness and group performance (Gavin & Ortega, 2016). This research suggested that people who hold similar values and attitudes to each other provide reassurance that their

beliefs are valid and accurate and that future interactions will likely be free of conflict; thus this similarity offers an immediate sense of unity (Arkin & Burger, 1980; Festinger 1950; Insko & Shopler, 1998; Newcomb, 1960). The literature also suggests that people are more likely to identify with groups that reflect positively on themselves as members and thus are drawn to groups seen as prestigious, high status, or high performing or that have an otherwise attractive image. Other studies challenge the earlier notion that the subjective value of the group is higher for more homogeneous groups. In their research that links diversity to effective work groups, van Knippenberg, Haslam, and Platow (2007) draw upon group (social) identification theory and propose that sometimes diversity rather than homogeneity fosters greater group identification; this occurs especially when people perceive the value of diversity for successful group performance and are thus likely to respond favorably to diverse work groups “precisely because of their diversity” (p. 208).

As groups form and cohesiveness develops, members become committed to the group and develop preferences for ideas, practices, and people associated with their group. The goal for this “intergroup” interaction is frequently to negotiate, learn, or work together across differences. Intergroup relations (IGR) units on many college campuses are one example of this type of conflict negotiation (Nagda, 2006a; Nagda, Kim, & Truelove, 2004). The goal is to share experiences, learn from each other about how privilege and oppression work, and join together to identify and work toward some common goals. Ideally, members will discuss how their other social categories are also relevant (e.g., how gender affects one’s experience of race). Other models are emerging that educate across multiple differences simultaneously or sequentially (Dessel, Rogger, & Garlington, 2006; Nagda, 2006b).

Social Structure

Group structure refers to how a group is organized, including such factors as group composition; power and status; group tasks; division of labor; boundaries; and norms. These structures may either enhance working for social justice or impede it.

GROUP COMPOSITION

Group composition is defined as the pattern that exists in the group related to the personal characteristics of the members or its degree of homogeneity or heterogeneity. Groups can be composed of people who are similar on a dimension of concern, who are selected to represent different characteristics, or who randomly represent differences on some characteristic. Each of these types of composition will present opportunities and challenges with regard to promoting diversity and social justice. In some instances, one can carefully select group members to represent particular types of diversity. Whether or not a group composition can be selected to maximize desired diversity, every group can develop group norms and procedures that solicit, value, and systematically take into account the different approaches, knowledge and skill sets, and worldviews of members. Such differences can be valued, worked with, and built upon.

A growing body of literature documents the consistent but complex effects of gender composition on a wide array of group conditions: dominance (Ridgeway & Diekema, 1989), legitimacy and status (Ridgeway, Diekema, & Johnson, 1995), communication patterns/interruptions (Karakowsky, McBey, & Miller, 2004; Smith-Lovin & Brody, 1989), and approaches to tasks. The salience of the social category is important (Randel, 2002), as is diversity in values (Rodriguez, 1998). These effects also depend on the nature of the task,

environmental conditions, and a variety of other factors, such as emotional responses (Butz & Plant, 2006), degree of participation (Li, Karakowsky, & Siegel, 1999), and so on.

POWER AND STATUS

As earlier noted, *power* consists of the degree to which members can influence the behavior of others by virtue of their position in the group, their ability to reward or punish others, their expertise, or their degree of attractiveness to others. A subset of members may attain or possess more power than other members by virtue of ascribed status (e.g., gender, social class, or ethnicity) and external roles. These power hierarchies can marginalize members with important knowledge and skills and create patterns of injustice in the group.

When the intersection of differences (e.g., race and gender) in group composition polarizes members along dimensions of distrust or inequitable participation, social justice strategies are necessary to find common ground (e.g., developing overarching goals), or at least to reduce some of the worst negative consequences of dynamics associated with conflict and connection that result in inequities (e.g., Fisher, 2000; Fisher et al., 2000).

The group is also affected by status characteristics outside the group that influence how people are perceived within a group, as well as power and influence structures within the group (Reed et al., 2010).

The term *status* indicates stable differences in the power and influence among group members (Garvin & Ortega, 2016). Some positions of status are earned (e.g., educational degrees, promotions in the workplace), but other types of status are associated with the social categories one occupies. Social categories that are commonly associated with different forms of ascribed status include ability, age, class, culture, ethnicity, family structure, gender (including gender identity and gender expression), marital status, national origin, geographic location (e.g., rural, suburban, urban), race, religion or spirituality, sex, and sexual orientation. Having higher ascribed status usually makes it more likely that a person will be able to acquire greater earned status. In social justice work, the consequences of having more or less ascribed power are frequently described as having privilege or experiencing oppression. People bring these experiences with them into a group and recreate them within groups in ways that are often not recognized.

Group members should be prepared to challenge those power and status dynamics that recreate gender-, race-, or other social identity-based inequities, as well as other patterns of societal injustice that emerge within the group.

GROUP TASKS

Group tasks, which group workers often refer to as its *program*, consist of the activities which members engage in together. Important issues to consider here include: Is the group attending to the ways that some tasks are preferred or rejected by people from different cultural groups or genders? Do members of various groups bring different assumptions and working styles to the tasks? (Garvin & Ortega, 2016).

DIVISION OF LABOR

The *division of labor* in groups refers to the task-focused patterns of action undertaken by members. Ideally, members assume tasks for the group based on their ability and interests rather than status. The group's division of labor should also encourage and support task

assignments that open new opportunities for members who have been oppressed or denied opportunities to contribute to the group's progress.

BOUNDARIES

Internal *boundaries* define the degree to which membership in and access to subgroups is easy or difficult to attain. Permeable boundaries allow members to build social connections within new subgroups or to reconstitute subgroups based on individual and group need. When permeable boundaries exist, communications are open among all subgroups. With rigid boundaries, members are “locked in” to existing subgroups, and communications are limited among subgroups. Such boundary patterns often ensue from issues of power and privilege and place barriers on the fulfillment of member and group needs.

Structural boundaries can also create insiders and outsiders—those within a subgroup derive support and status from other members, and those not included can be marginalized and acquire less power and satisfaction (Staples, 2000).

NORMS

Norms in groups refer to the expectations members have as to how other members should behave or refrain from behaving. These norms are shaped by societal assumptions (Ridgeway, 2001) in which beliefs about societal status create a network of expectations that then shape people's behaviors. Members are frequently rewarded or punished if they follow or violate shared expectations, sometimes overtly by being expelled from a group or explicitly sanctioned. Often, however, not “fitting in” leads to a gradual loss of influence and social connections in a group.

Unjust or inflexible norms can contribute to scapegoating and marginalizing, and leave some members more central than others in terms of power and status. This may be related to gender, ethnicity, age, social class, and other demographic characteristics and related behavioral expectations.

Group Culture

The group for parents with children recently diagnosed with autism opened their initial session by writing four descriptions of themselves on a picture of a shield divided into four quadrants. Members were asked to describe their shield to the person sitting next to them (not a spouse) and when it came time for members to introduce themselves, the paired members were instead asked to introduce each other. Afterward, members were invited to share how it felt, what they noticed most about what they identified about themselves, and the accuracy of their paired person's understanding of their descriptors.

Culture is defined as the shared beliefs and traditions that exist among the members of the group and the ways in which group members create meaning within the group. Some aspects of a group culture may be very conscious, overt, and obvious to group members—for instance, its explicit rituals or rules for behavior—whereas others are more subtle (Reed et al., 2010). Participation may emerge in groups that replicate stereotyped participation outside the group based on gender, socioeconomic class, age, and so on. Cultural elements can also include the theories or intervention models being employed in a group.

Key cultural elements include norms, symbols, and rituals, taken-for-granted assumptions that explain key group phenomena and the words used to signify their meaning.

Meaning-making processes can be very subtle—what Martin (2003) calls *liminal*—meaning beyond the awareness of most participants (Reed et al., 2010). One might also call them *tacit*, meaning not articulated or recognized and maintained in the day-to-day interactions and thoughts that are taken for granted. Often these processes become difficult to change, especially when left unattended.

What creates legitimacy also has cultural elements. Johnson, Dowd, and Ridgeway (2006) describe how legitimacy is shaped by beliefs and then, in turn, secures compliance with the existing social order (Reed et al., 2010). This order is embedded in shared and accepted (or at least not questioned) beliefs, norms, and values. These authors describe some ways to disrupt these shared assumptions. One of these is that group members can critique the knowledge, values, research, theories, and practice methods/actions being used in the group in terms of underlying paradigms and the assumptions they represent, illuminate, or obscure.

Group Development and Process

Group process refers to how the group changes from moment to moment or over longer periods through member interactions, including enactment of procedures and tasks in the group (Garvin & Ortega, 2016). These interactions include group members' communications, affects, and conflicts and the patterns among these as the group begins and, over time, seeks to accomplish its purposes and goals. This latter process is referred to as "group development." Processes such as how decisions are made or the unfolding of a conversation among several people are also strongly affected by the larger social contexts in which members and groups are embedded. Group members' culture, gender, and other status issues previously discussed matter to the extent to which much of what matters most to members and their integration into group processes and development become highly relevant. For example, people with perceived higher social status often talk more, express themselves differently, and interrupt others more than do those members who may perceive themselves as having less status, and there are marked differences across cultures, as well (Karakowsky et al., 2004; Smith-Lovin & Brody, 1989). For example, the pattern of positive and negative emotions that members direct at others in the group are likely to shape subgroups and the overall climate of the group (Ridgeway & Johnson, 1990).

Group processes can be overt and covert (Garvin, 1997). Overt refers to occurrences that are observable and explicit, such as communication and behaviors that members direct toward one another. Covert refers to thoughts, feelings, and nonverbal forms of communication manifested in member interactions and expressed values. Garvin's (1997, pp. 104–109) dimensions of process offers a useful way to examine how group process takes into account a social justice viewpoint as group members work together. Aspects of process such as goal determination, goal pursuit, values and norms, role differentiation, communication and interaction, conflict resolution and behavioral control, and emotion help in considering how the multiple opportunities for influence and change in a group come about and ways to analyze how social justice matters are taken into account as groups proceed.

There have been a number of attempts to conceptualize change that occurs as groups develop. Tuckman and Jensen's (1977) stage model of forming, storming, norming, performing, and ending is well known. Other developmental models have emerged but for the most part groups are more often viewed as moving through phases rather than stages from pregroup, through a beginning, a middle, or a transition phase, and ideally resulting in a planned ending. Throughout these phases important aspects of social justice work come

to fruition as members engage in a socially integrative process that situates them as a part of the group while maintaining their independence and identities. Group development that does not adhere to the many ways that social injustices emerge as previously discussed (e.g., micro-aggressions, imposition of power and status hierarchies, etc.) will promote anxiety, discomfort, and either loss of membership or member exploitation, in either explicit or subtle ways, or some combination of both.

Attentiveness to social justice work emphasizes the importance of work in the beginning that often moves members from tentativeness to engagement. In the transition or middle stages, groups are characterized by collaboration and productivity. Problem-solving methods emerge to facilitate their work and conflict management that normalizes differences allows members to respectfully disagree yet continue their work. Associations with belonging, comfort, cohesion, and so on accompany members working together in the transition or working phase.

In the ending phase, the completion of tasks, insights gained about personal challenges, reduction of sources of emotional turmoil, and so on mark the achievements of members being and working together. Social justice work requires additional tasks that ensure the development and adaptability of skills and gains made while participating in the group. Since each group is unique in terms of open or closed membership, time limits on number of sessions, sponsoring organization, member composition, and so on, enormous challenges will have been addressed to pave the way for each member to be recognized and validated for their diverse identities, for members to appreciate their views and respect the limitations of these views, and leave the group equipped with knowledge and skills and a vision of what a socially just world could look like. In addition, knowledge and skills will also illuminate ways to combat social injustices in meaningful ways in their personal, interpersonal, and social life.

Group Leadership

Leadership in groups refers to an individual acting in ways that increase the effectiveness of a small group, while working toward social justice (Garvin & Ortega, 2016; Reed et al., 2010). Although many groups have a designated leader or leadership team, either appointed by some external authority or emerging from the group, every group member can exert leadership by contributing to the evolution and accomplishments of a group. A social worker will contribute leadership in many ways, not just when in formal leadership roles (e.g., chair, president, facilitator).

A review of articles focused specifically on social justice in groups identified common themes regarding leadership that are considered central to social justice work (Singh & Salazar, 2010). Core among these themes were the leaders' willingness and ability to expand their understanding and appreciation of diversity and cultural differences and openness to different expressions of language.

The importance of attending to, planning, and mobilizing member skills and abilities to address identified social injustices and misuses of power and privilege within and outside the group and of facilitating member empowerment emerged as a second theme. Collaborating to increase knowledge and skills that challenge the unequal access of goods and services and that teach self-advocacy and community-level advocacy were also emphasized, as were specific social justice goals to address underrepresented populations and issues. Leaders are challenged to utilize social justice skills that expand beyond identity differences, such as working across race or ethnicity, gender, or social class and working to address injustices that often discriminate across multiple differences.

Another essential theme focuses on the leaders' ability to examine carefully and openly how their own privilege may impede their ability to experience members' concerns in ways that reveal their origins in marginalization and oppression. Leaders are called upon to "unpack" their invisible knapsack of power and privilege (McIntosh, 1988/2000) and to reflect on how this content may lead to positionalities and standpoints that create barriers to experiencing members' concerns and challenges to effective practice as these aspects are expressed by members at different times in the group. From a social justice perspective, leaders are urged to develop practice skills that ensure attention to members' experiences and needs and expand their own learning about themselves beyond what occurs within the group itself.

The fourth core theme focuses on leaders' consciousness raising and the actions that ensue from this process. As group members increase their awareness, develop a clearer sense of the interplay of power, privilege, marginalization, and oppression as systemic problems, and feel empowered (along with the urge to "do something"), a leader's abilities should assist members in ways that enable them to advocate for themselves. As members emerge from the group with social justice visions, leaders will ideally teach them strategies to promote effective change. Group leaders will be more successful when deficit-oriented perspectives are transformed into more meaningful and hopeful perspectives accompanied by the knowledge and skills to make and sustain change toward social justice causes.

Leadership and Justice

The literature continues to document that leaders who occupy higher and lower power social status categories are perceived and reacted to differently by group members. Gender expectations continue to shape what is possible for women in leadership roles, although less than they did earlier; women are now perceived as being as competent as men in many studies, although they elicit considerably more negative affect than men do (Carli & Eagly, 2001; Eagly, 2007; Koch, 2005). The situation for leaders in different racial categories is considerably less clear, with some studies suggesting that they are perceived as less competent and others finding that they are rated more favorably than whites in leadership (Ellis, Ilgen, & Hollenbeck, 2006; Kelsey, 1998; Pyke & Johnson, 2003).

Another factor that is important to consider is that those wishing to exert leadership represent all social categories. Just because one has experienced oppression does not automatically prepare one to have skills in working for justice. The literature is just beginning to address strategies useful for people of color in leadership positions (e.g., Marbley, 2004).

CONCLUSION

A major theme throughout this chapter is that the very elements that can make living and working in groups such a positive force within society may also create conditions that disempower members, lead to inequities, promote injustices, and sustain the kinds of injustices that endure in society. We assert that this is likely to occur unless group members and leaders are constantly vigilant about unintended consequences or else are willing to confront intentional acts that unjustifiably privilege differences among participants.

Definitions that focus on the struggle for justice describe a deep commitment to an ongoing engagement with and understanding of the dynamics and forms of privilege and oppression. Skills also include working with people with diverse experiences, social locations, and perspectives toward socially just relationships, procedures, decision-making processes, and environments.

Barriers to justice exist in mechanisms for privilege and oppression that must be understood and challenged as goals in themselves and as recurring processes in all social environments and systems. These barriers may be expressed in the structures found in the group, as well as in the interactions between the group and the larger society. All are associated with social categories/positions with and without power and influence and are maintained and can be challenged and changed through work in small groups.

We have integrated issues related to justice and injustice, along with a presentation of many basic concepts important for a general knowledge about small groups and the many important purposes they serve. We have stressed recognizing and engaging with multiple sources of power and all the types of conflict that are inevitable in the pursuit of social justice. We have also submitted values that undergird all efforts to engage in socially justice practice with regard to solidarity, tolerance, inclusion, cultural humility, empowerment, and shared leadership. This values orientation and knowledge of groups and social justice is meant to challenge group work practitioners to continue to acquire resources, seek out additional literature as it becomes available, and continue to engage with and learn from the members themselves.

NOTES

1. In Townsend et al. (1999), see chapters by Townsend and Zapata, pages 1–18; Townsend et al., pages 19–45; and Zapata, pages 150–163.
2. There may also be other characteristics to be considered in addition to those named here.

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PART II

PRINCIPAL FOUNDATIONS OF GROUP PRACTICE MODELS

INTRODUCTION

When group work was first conceptualized as a social work method, group workers presumed that they were using a common set of assumptions and had a common purpose. As group work in social work evolved, it became evident that group workers were diverging from one another by thinking of group purpose in different ways, seeing the worker's role differently, and utilizing some different theories and practice principles. The theories were not completely different. The kinds of social psychological terms presented in Chapter 1, for example, are likely to be found in the concepts used by most, if not all, group workers. Several authors sought to analyze the group work models that were emerging. Papell and Rothman (1966), for example, described three models they termed *social goals*, *remedial*, and *reciprocal*. A few years later, Roberts and Northen (1976), as editors, asked a group of writers on group work whom they believed had created distinct group work approaches to present their "models." These writers also met together to discuss each other's work, and Roberts and Northen, in a published book of these presentations, created a comparative analysis of these approaches.

We decided in this book not to seek to update the work of Papell and Rothman or of Roberts and Northen. We believe that group work practice has become too eclectic to permit a neat typology of group work models. Rather, we relied on each of the contributors to this volume to portray the models most pertinent to their topics. We did not, on the other hand, choose to relegate the issue of practice theory solely to these authors. We selected two perspectives for this section that represent different emphases that are often cited in group work books and articles. One influential tradition is referred to by many writers as the *mutual aid* model. This model draws extensively on principles of mutual aid, democratic decision making, and the importance of understanding the quality of member-to-member interactions, and Chapter 7 presents this set of ideas.

Another influential tradition has emerged from an emphasis on member goal attainment, the ways members and workers influence each other, and the cognitive-behavioral concepts that deal with member influences and achievements. Chapter 8 explicates these ideas. An understanding of mutual aid is also utilized by writers in this tradition.

The concept of mutual aid can be used to cover a broad variety of interactions in the group, such as how well members understand and use the concept, how many and which members are involved in mutual aid at any given time, what the form of inter-member helping takes, and what the outcomes of these interactions are. Recently the practice committee of the International Association of Social Work with Groups has taken up this topic and is developing a research program to study and clearly define mutual aid processes (Garvin, 2015).

We do not believe that writers on any of the current models of group work exclude reference to other models. Many practitioners draw upon several, even though there are differences in terminology. Some writers, such as Galinsky and Schopler (1989), have sought to reconcile differences.

We also recognize that there are differences when social workers facilitate groups in clinical as compared to macro settings, and some writers in this book provide a conceptualization of macro group work practice, such as Ephross and Vassil (1988) and Fatout and Rose (1995). This area of group work is receiving more attention, and this development is exciting. For this reason, we present various macro applications of group work in Part V.

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CHAPTER 7

The Mutual Aid Model

ALEX GITTERMAN

The mutual aid model is embedded in group work's historic social goals tradition. William Schwartz, its major proponent, elaborated and refined the social goals' philosophical and value base by proposing a bold conception of social work function, phases of helping, mutual aid, and professional methodology. This chapter traces the historical context of the mutual aid model and Schwartz's distinctive contributions to its formulation. It presents his ideas and those of others, particularly in the conceptualization of a unique social work function, the specification of mutual aid processes, and the identification of specialized group work methods and skills. The chapter concludes with a practice illustration of mutual aid at work.

HISTORICAL CONTEXT

The history of group work and the mutual aid model are inextricably interwoven. In contrasting group work history to that of casework's one-on-one approach, Schwartz (1983/1986) wrote:

A second direction has been to help needy people in their own milieu, surrounded by their peers and working in an atmosphere of mutual aid. Here the effort is to find, in the people's own conditions of life, the energy and resources with which they can help each other to act on common problems. People are brought together for many reasons: to organize themselves for action on special interest and common concerns; to help each other face difficult problems; to learn new skills with which to enrich the quality of their lives . . . experiences are communicated among the members . . . and the worker is surrounded by a host of surrogate helpers, each claiming a share of the supportive function. The lines of communication are intricate, and the worker's authority is diffused in the network of relationships that goes to make up the pattern of mutual aid. This is the direction we came to know as social group work. (pp. 7–8)

Social group work emerged from the settlement, recreation, and progressive education movements (Gitterman, 1979, Gitterman & Germain, 2008). These movements articulated two primary functions for small-group experiences. Some leaders emphasized using the small group to socialize members, whereas others emphasized using the small group to maintain a democratic society (Reid, 1991, p. 24).

From the settlements, group work derived its institutional base. Settlement leaders deeply believed in democratic group processes for the development of responsible citizenship, mutual aid, and collective action (Gitterman & Germain, 2008; Lee & Swenson, 1994). They divided their attention between developmental and citizenship experiences and environmental reform. They also used small-group experiences to build character and teach social skills. Group leaders were expected to model social values (Addams, 1910, 1930; Lee, 2009; Malekoff & Papell, 2012; Wald, 1915).

From the recreation movement, group work gained its interest in the value of play, activities, movement, and action. Initially, recreation and play were primarily used to fill leisure time and recreational needs. Later, activities were used to socialize members, build their “character,” and instill a sense of competence and mastery (Bergart & Clements, 2015; Lee, 1931). Camping stressed the importance of interaction with the natural environment, its appreciation and effective uses (Lieberman, 1931). The settlement and community center leaders incorporated recreational methods and programs into their services.

From progressive education, group work acquired a heuristic philosophical base (Dewey, 1916, 1938; Kilpatrick, 1940). Dewey emphasized the use of group process—peer learning—in the classroom. Dewey believed that participation and experience in democratic groups was the most effective means for learning and perpetuating democracy. His philosophy of education drew on the democratic ideal, reflecting the inspirations and visions of the settlements. The writings of Follett (1924, 1926) and Lindeman (1924, 1926) also provided group work with its philosophical base.

In the late 1930s, the settlement and community center, recreation, and adult education movements flourished. Practitioners from the various settings identified common interests and visions and formed the American Association for the Study of Group Work (AASGW). In its early development, a few distinctive characteristics differentiated group work from casework. Reid (1991, p. 27), citing Pernell (1986), identifies these differences:

the emphasis on member versus clients; doing with versus doing for; doing versus talking about doing; activity and others as primary agents in the helping process versus the worker alone as the primary agent; personal and social development and social contribution as legitimate professional foci versus a remedial and rehabilitative focus; health and strength versus sickness and breakdown.

Professional differences in emphases were not limited to casework and group work. Among group workers, the practice of group work had different meanings and visions. In the 1940s and 1950s, group work practitioners and educators attempted to define the boundaries and functions of group work and to develop a conceptual base. The number of schools of social work with a group work specialization increased and resulted in the “method” becoming more “generic” and less setting bound.

Using ideas and research findings from sociology, social psychology, and group dynamics, a common core knowledge base began to emerge in the group work literature (Coyle, 1930, 1937; Crampton, 2009). Related to this was an ongoing struggle to make sense of the diverse and competing demands placed on the burgeoning “method.” Some leaders

perceived group work as a social movement; others defined group work as a field of practice, identifying agencies with a common practice base. Still others began to define group work as a distinct process and method. To incorporate the varied definitions and interests, the boundaries and functions of group work were defined quite broadly: (1) the growth and development of the individual; (2) the development of the group; (3) the development of a democratic society. The writers searched for the elusive link between the needs of the individual and the needs of society, individual health and social participation, individual responsibility and democratic society. To fulfill this elusive but interrelated link, various educational, cultural, socialization, and social action functions were elaborated (Papell & Rothman, 1966). Broad premises and goals were in the foreground; professional methodology remained in the background.

In 1946, AASGW members voted to become the American Association of Group Workers (AAGW), a professional organization. And, in 1956, AAGW was incorporated into the National Association of Social Workers (NASW). Integration of AAGW with NASW brought group work fully into the profession. During the same period, group work practice expanded into clinical settings. These settings required “new psychological insights and understanding on the part of group workers” (Alissi, 1980, 2009). As group work practice became more diverse, the Committee on Practice of the Group Work Section of the NASW assumed responsibility for developing working definitions and for establishing a frame of reference for social group work practice. A number of practitioners and educators were invited to prepare statements on these subjects; 10 were published (Hartford, 1964). Although participants were unable to agree on a common definition and frame of reference, the discussions renewed interests and identified critical knowledge gaps—particularly an underdeveloped professional methodology. Group work scholars further advanced the “method’s” knowledge base, but professional group work methods and skills continued to be underdeveloped (Coyle, 1947, 1948; Konopka, 1949, 1954; Phillips, 1951; Trecker, 1955, 1956; Wilson & Ryland, 1949). It is important to note that during this period McCarthyism led to a general suspicion of group participation (Andrews & Reisch, 1997).

In the early 1960s, the writings of Vinter and Schwartz received wide attention and interest because of their common concern and commitment to the development of a professional methodology. Vinter (1967) moved toward the paradigm used by caseworkers of social study, diagnosis, and treatment. The group represented a context for the treatment of individuals with difficulties in social functioning. Vinter’s emphases on individual behavioral change and professional methodology supported group work’s integration into casework agencies and departments and into greater acceptance by the professional community.

Schwartz, whose approach is a major focus of this chapter (1961, 1962), shared Vinter’s primary concern for the development of a professional methodology. He proposed a bold and ambitious paradigm through which he attempted to elaborate and refine the social goals tradition rather than move toward the casework paradigm (Gitterman, 1979). His “reciprocal model” is referred to as the *interactional model* and, more recently, as the *mutual aid model*. The idea of “reciprocal” captures the mutually dependent relationship that exists among members within a group and between the group and its social environment.

Schwartz used the term *interactionist approach* to emphasize the interaction between people and external systems. Schwartz was probably the first to introduce the term *mutual aid* into social work scholarship and was its major proponent (Steinberg, 1997, 2009). Shulman (1986, p. 51) states that of the many scholarly contributions Schwartz made to social work, “none has been as important as his conceptualization of social work groups as enterprises in mutual aid.” Thus this chapter is titled “The Mutual Aid Model.”

MEDIATING FUNCTION

Schwartz (1961) used systems theory to develop his conception of a mediating function for the profession of social work. He suggested that the concept of function “implies the existence of an organic whole, a dynamic system, in which the worker performs certain movements, in relation to the movements of others” (p. 151). He went on to say that a functional statement must “reflect the activity of the social worker as it affects, and is affected by, the activity of others within the system . . . to see the system as one within which relations determine the properties of its parts” (p. 152). Schwartz (1976) further suggested that within the social system the individual possesses a natural impetus “toward health, growth and belonging” and a similar natural impetus of society to “integrate its parts into a productive and dynamic whole” (p. 1258). He viewed the existence of a “symbiotic” relationship between individual and social needs¹: “A relationship between the individual and his nurturing group . . . can be described as symbiotic . . . each needs the other for its own life and growth and each reaches out to the other with all possible strength at a given moment” (1971b, p. 1259).

In a highly complex society, the symbiotic relationship becomes obscure, obstructed, diffuse, and tenuous, as “people are weakened in their reach to the system and the system is too clumsy to incorporate the people it needs to serve” (Schwartz, 1994, p. 114). Therefore, the profession of social work is required to deal with all the strains that develop between people and their social systems: “it works with the individual to use his system and it works with the systems to reach its people” (Schwartz, 1994, p. 115). The obstacles to reciprocal individual and societal need fulfillment provide social work with a distinctive professional function: namely, to mediate the transactions between the group and societal institutions and between individual members within a group. In other words, groups face two primary challenges to their elaboration and survival: (1) to deal with external, environmentally induced stressors and (2) to deal with internal, interpersonally induced stressors. Consequently, the worker’s primary function is to help a group and its members to establish and maintain a favorable interchange with the environment and a mutual aid system among its members. When successful in these twin challenges and tasks, a group may be said to be in adaptive balance.

External Mediation

To actualize this conception of a mediating function, social workers represent their groups and members, as well as their employing organizations. They identify with their common need to engage each other rather than with one over the other. If social workers align themselves solely with their group members and disown their employing agencies, they will diminish their credibility and ability to help group members obtain agency resources. Similarly, if social workers align themselves with the employing agencies and “become” their organizations, they lose their credibility with group members. The professional task is to represent the employing organization without becoming or disowning it (Gitterman, 1986). The focus is on improving the fit between members’ needs and agency services. In doing so, “the practitioner is required neither to change the system, nor to change the people, but to change the ways in which they deal with each other” (Schwartz, 1969, p. 41).

Internal Mediation

In dealing with environmental pressures and internal group processes, members encounter interpersonal tensions and obstacles. Dysfunctional communication and relationship

patterns are generated in the system, hindering mutual aid processes. Withdrawal, factionalism, alliances, and scapegoating are illustrative of these dysfunctional patterns (Berman-Rossi, 1993; Bogdanoff & Elbaum, 1978; Brown & Mistry, 1994; Galinsky & Schopler, 1994; Germain & Gitterman, 1996; Gitterman, 1989, 2003a, 2012; Gitterman & Germain, 2008; Gitterman & Wayne, 2003; Malekoff, 1997; Shulman, 2011; Steinberg, 1996, 1999; Wayne & Gitterman, 2003). To mitigate these maladaptive patterns, the worker must identify the pattern and encourage members to change their behaviors. Usually, members are reluctant to change an entrenched and comfortable pattern because it protects them from dealing with painful material and issues related to interpersonal intimacy. Scapegoating, for example, may stave off difficulties in the group while promoting difficulties in the scapegoated member (Antsey, 1982; Shulman, 1967). The worker must be direct and persistent in challenging dysfunctional patterns and be comfortable in dealing with avoidance, as well as conflict. By relating to negative feelings and thoughts, the worker conveys a faith in group members' abilities to confront difficult issues. During these difficult discussions, group members require support and credit for their willingness to struggle and to risk themselves.

PHASES OF HELPING

Schwartz (1971a) placed the mutual aid processes within four interrelated helping phases: preparation, or "tuning in," in which the worker prepares him- or herself to move into the group experience; development of a mutual agreement, or contract, in which the worker helps group members to develop a common focus; the actual work, in which members deal with group tasks and any obstacles that impede mutual aid processes; and termination, in which members separate and the group ends or the worker leaves.

In the preparation phase, the worker acquires essential organizational sanctions and supports; formulates group purpose; composes the group (or, at least, considers the implications of an externally composed group); pays attention to time, size, space, and recruitment factors; and anticipates members' possible reactions to the first meeting (Gitterman, 1994; Gitterman & Germain, 2008; Kurland, 1978; Northen & Kurland, 2001). In the second phase, contract, the worker helps members to reach a common agreement about what they will work on and how they plan to go about it. Essentially, the worker's task is to help the group develop a clear and mutual agreement about group purpose and respective responsibilities (Garvin, 1969, 1997; Gitterman, 1986; Gitterman & Germain, 2008; Kurland & Salmon, 1998; Shulman, 2011; Toseland & Rivas, 2011). According to Schwartz (1971a), "The contract, openly reflecting both stakes, provides the frame of reference for the work that follows, and for understanding when the work is in process, when it is being evaded, and when it is finished" (p. 8).

Members require a clear understanding about the group's purpose in order to evaluate appropriateness and suitability. Informed members are less likely to fear a hidden agenda and more likely to be receptive to an offer of help than uninformed members. The worker must also invite members' reactions to the offered group services. There are potentially differing perceptions among the agency, the worker, and the group members. For example, children referred by a teacher for being "troublemakers" will resist such an offer of service. In contrast, a statement that takes into account the youngsters' perceptions—"I sense that the school hasn't been much fun and that you may feel teachers and other kids pick on you"—will more likely be positively received. Taking into account members' perspectives on

their life issues encourages mutually supportive behaviors rather than mutually exploitative behaviors. Group members also need to know that they are meeting with a social worker and have some idea about what social workers do. Children in a school group, for example, will use their teachers as role models for expected adult behaviors. With discrepant expectations, mutual aid can be inhibited.

In the work phase, Schwartz (1971a, p. 16) identified four major tasks for the group worker:

1. Finding, through negotiation, the common ground between the requirements of the group members and those of the systems they need to negotiate.
2. Detecting and challenging the obstacles to the work as these obstacles arise.
3. Contributing ideas, facts, and values from his or her own perspective when he or she thinks that such data may be useful to the members in dealing with the problems under consideration.
4. Defining the requirements and limits of the situation in which the client–worker system is set.

The subsequent sections of this chapter describe and illustrate the skills required to carry out these tasks. The ending phase makes specific demands on the group members and the worker. These demands include dealing with the feelings aroused by the ending, processing various termination phases, planning for the future, and reviewing and evaluating the group experiences. Like the initial phase and the ongoing phases of practice, the ending phase requires the worker's sensitivity and range of professional skills (Gitterman & Germain, 2008; Irizarry & Appel, 1994; Nadelman, 1994; Shulman, 2011).

MUTUAL AID

Schwartz (1961) perceived the social work group as

An enterprise in mutual aid, an alliance of individuals who need each other, in varying degrees, to work on certain common problems. The important fact is that this is a helping system in which the clients need each other as well as the worker. This need to use each other, to create not one but many helping relationships, is a vital ingredient of the group process and constituted a common need over and above the specific task for which the group was formed. (p. 19)

An agency-formed group is composed of individuals who come together under the agency auspices to work on common life issues, interests, and tasks. If members quickly develop a sense of common purpose, they will begin to share common experiences and concerns. Initially, group members present safer and less threatening issues to feel out the worker's and each other's trustworthiness and genuineness. And through a testing process—sometimes quite overt, at other times much more subtle—group members begin to develop and reinforce mutual bonds and alliances as they process the roles of each member and the worker in the group's interpersonal system. When members experience collective support and individual comfort, they develop an increased willingness to risk more personal and sometimes taboo concerns (Gitterman, 1986, 1989; Knight & Gitterman, 2014).

Hearing others' life issues often helps group members to experience their difficulties and stressors as being less unique and deviant. From these exchanges, members feel less isolated, stigmatized, and pathologized. Learning to share and to reach out to each other, members experience a "multiplicity of helping relationships," with all members invested and participating in the helping process rather than the worker alone assuming that function and role (Schwartz, 1961, p. 154). Because they may have had similar life experiences, they are often receptive to each other's views and suggestions. The group experience itself is a microcosm of members' interpersonal self-presentations and therefore serves as a rich arena for members to examine their respective adaptive, as well as maladaptive, perceptions and behaviors. From these exchanges, members are helped to develop and practice new interpersonal and environmental strategies and to receive feedback on such efforts (de Jong & Gorey, 1996; Gottlieb, 2000; Gregory & Erez, 2002; Hopmeyer & Werk, 1994; Kinnevy, Healey, Pollio, & North, 1999; Pepler, Catallo, & Moore, 2000; Pomeroy, Rubin, Laningham, & Walker, 1997; Springer, Lynch, & Rubin, 2000; Tutty, Bidgood, Rothery, & Bidgood, 2001).

Groups also provide the impetus for members to act and gain greater control and mastery over their environments. Collective action achieves greater organizational and community attention, increases the likelihood of success, and mitigates individual isolation and reprisals. The opportunity to participate in a group and to influence one's environment provides a sense of competence and efficacy. Mutual aid provides groups their energy, drive, and momentum.

Shulman (1986, 2011) divides mutual aid into distinct processes evident in effective groups. Group members have accumulated varied life experiences. Through the processes of sharing of relevant data, members serve as a significant resource to each other. As members share their perspectives on life issues and concerns, a dialectical process takes place through which members discuss, challenge, argue, and, through the give-and-take, develop greater clarity and personal synthesis. For mutual aid to deepen, members learn to explore taboo concerns. They find their voices and courage to explore buried material. Listening to each other's troubles, members experience the "all in the same boat" phenomenon. They discover that they are not alone in their experiences, reactions, and coping efforts. This realization has a special healing value: "Guilt over 'evil' thoughts and feelings can be lessened and self-destructive cycles broken when one discovers they are normal and shared" (Shulman, 1999, p. 306). Learning that others are in the "same boat" expands members' perspectives and helps members to universalize their life struggles. Oppressed and vulnerable populations often internalize societal stigmatization. Members raise their consciousness when they expand their perspective on their difficulties and take into account the external contexts for their troubles.

In sharing and universalizing common life issues, group members empathically understand each other's experiences and reactions in a deep and personal manner and are able to provide genuine mutual support. Group members' empathy and support allow members to "accept their own feelings in new ways" (Shulman, 1999, p. 308). Members provide each other with mutual support not only through expressions of caring but also through mutual demands for them to "risk their real thoughts and ideas, listen to each other, put their own concerns aside at times to help another" (Shulman, 1999, p. 309). In helping another, the person becomes engaged in individual problem solving. By helping an individual solve a problem, group members are also helping themselves to deal with similar issues. A particular form of problem solving is rehearsal, through which group members try out new behaviors in a safe environment. And when the focus is on collective rather than individual

problem solving, the group provides a “strength in numbers” that increases courage and lessens risks.

To actualize these mutual aid processes, Gitterman (1989) identifies essential professional group work tasks, methods, and skills. Early in a group’s life, members usually speak to and through the worker. To facilitate mutual aid processes, the worker directs members’ transactions to each other. Initially, members may talk at each other rather than to each other. The worker helps members to build on each other’s contributions by linking their comments to each other. The worker identifies and focuses on salient group themes. Common salient group themes are the “glue” that bind members together as they help each other with mutual concerns and issues.

In previous groups, members may have learned to compete with, withdraw from, and/or exploit each other. To mitigate these dysfunctional patterns, the worker encourages and reinforces cooperative mutual support norms. Primarily, the worker who models, teaches, and credits their expression achieves these norms. As another method for creating mutual support norms, the worker may help group members examine their interpersonal system of rewards and punishments—their system of sanctions. These include implicit and explicit statements of approval through praise and recognition, disapproval, and stronger sanctions, as well as interpersonal punishment that may range from mild rebukes and teasing to more extreme responses, such as scapegoating and ostracism. The worker helps group members to develop clearer behavioral guidelines and greater interpersonal acceptance. “When members are clear about what behaviors are preferred, permitted, proscribed and prohibited, they are likely to be less anxious and more available to each other” (Gitterman, 1989, p. 13).

Encouraging group members to participate in collective activities also facilitates mutual aid processes. Participation in role play, sports and games, arts and crafts, and music and dance, as well as in social action, requires members to interact and communicate, to plan and make decisions, and to differentiate roles and tasks. The worker and group members (when possible) must assess their readiness and motivation to undertake collective activity. By encouraging collective activities and by experiencing collective successes, the group’s mutual aid processes are further elaborated. So that they may participate effectively in collective activities, the worker clarifies members’ tasks and role responsibilities. Specification of tasks and role assignments facilitates mutual aid processes by integrating members and by reducing conflict and stress associated with ambiguity.

Some groups are disorganized, and members have difficulty with planning and decision making. Members require help learning such processes as achieving consensus and compromise. In these groups, the worker must, at least initially, structure planning and decision making. Gitterman (1989) offers an example of a group of disadvantaged older adolescent boys. They were unable to plan, to solve problems, or even to sustain a simple, focused discussion.

A member’s comment would be immediately punctuated by another member’s sneer or jeer about a girlfriend, mother, and so on. Chaos invariably followed! Since they had neither experienced nor learned the value of collaborative decision-making, they needed structure to facilitate collaborative processes. The worker developed an interactional sequence with them to use in planning any program or making any decision. 1) In a round robin fashion each member presented one idea at a time, the worker recorded each idea on a large master list. The round robin continued until all members’ ideas were expressed (during this step no comments or alternative suggestions were allowed). 2) The worker limited discussion about each alternative to clarification and identification of potential problems. 3) After

group members eliminated duplicate ideas and voluntarily withdrew impractical alternatives, members voted for the preferred plan or decision. The prescribed sequence provided a structure for decision-making and eliminated disabling criticisms and harshness. And as members learned to listen to each other, interpersonal support and competence replaced interpersonal exploitation and inadequacy. (p. 14)

The worker uses these professional tasks, methods, and skills to integrate members and to nurture mutual aid processes. Although strengthening collective functioning is essential to mutual aid, it is not sufficient. The worker must also be responsive to the needs of each individual member, as well as to the needs of the collectivity. This responsivity requires the worker to help each group member to negotiate his or her individual needs to be different and separate and not simply “fit in.” The worker uses additional skills to help a group to develop a satisfactory balance between meeting the needs for group integration and individuation.

To meet the needs of individual members, the worker must be extremely careful not to stifle divergent perceptions and opinions. Premature consensus subverts mutual aid processes. The worker reaches for and pursues discrepant perceptions and opinions. By inviting and encouraging individual members to disagree, to have differing opinions and perceptions, the worker supports a group norm of accepting individual differences. As Gitterman (1989, p. 15) points out, “A collectivity is only as strong as its ability to allow and tolerate differences. Members can only be supportive of each other, if they feel sufficient comfort to state their thoughts and feelings openly.”

For various reasons (discomfort with content or pace of conversation, shyness), some group members may have trouble participating. With caring and support, the worker invites and pursues the participation of the member who feels “outside” of the group process. This behavior conveys and models to all group members their individual importance. Often, more than one invitation is necessary; therefore, the worker demonstrates interest and caring through several invitations.

Group members desire different degrees of intimacy and distance and of group solidarity and individual distinctiveness. Some members need greater separateness and space than do others. The worker attempts to help group members to negotiate a comfortable balance and supports a member’s need for greater emotional and physical space.

Essentially, as members feel more comfortable and less threatened, they become more invested in each other. They become willing to take chances and to lower their defenses when their individual styles and rhythms are respected and valued. Thus, for the worker, a critical professional task is to balance individual needs with group needs.

Relationship and communication obstacles are phenomena inherent in a group’s life. Members usually have some ambivalence about intimacy, about being close to each other and to the worker. As members work out such issues, they become closer and more supportive and helpful to each other. Usually, with the worker’s encouragement and professional skills, the interpersonal tensions diminish, and energies are released for the agreed-on tasks. When the worker ignores the obstacles or unskillfully deals with them, they become entrenched and threaten the group’s existence. The worker thus has to have confidence in the members and in his or her abilities to deal with the maladaptive patterns. By meeting the challenge, members have the opportunity to gain greater self- and collective confidence and to learn about the quintessential meaning of mutual aid (Getzel, 2014; Gitterman, 2011; Rosenwald, 2007; Steinberg, 2004, 2010).

PRACTICE ILLUSTRATION

A social work intern led an educational group of at-risk 17- to 24-year-old gay males. They were sexually active, practiced unsafe sex with their friends and with anonymous partners, and were at high risk of HIV infection. The initial purpose of the group was to provide information about harm-reduction behaviors (Gitterman, 1999; Knight & Gitterman, 2014).

The group met weekly for 10 weeks. Seven members (three white, two Latino, one African American, one Asian American) composed the group. Most members lived independently but were partially or fully financially supported by their parents. In screening interviews, members openly described their high-risk behavior as passive partners of anal intercourse without condoms or active partners of oral sex without condoms. Although they were aware of their risky behaviors, they presented as uninterested in changing them. However, they all agreed to try the group. In the fifth session, the intern records:

Jack stated, "I had a really rough day yesterday. I told my parents that I was not going back to school next semester and that I am going to take the semester off and they became really upset. They think I am lost or something. My mother was crying, and she never cries. It really upset them. I didn't expect it. They've been worried about me. They think my life is going nowhere. They told me that I am not the son they wanted me to be and that I had disappointed them." *I emphatically shook my head from side to side.* Jack went on, "I know they think I am not going to finish school because I am gay. Ever since I came out to them three years ago, they think my life has gone downhill. They think I have all of these negative influences in my life and that the negative influences made me decide not to return to school. I'm so pissed off at them, but it's hard because they have done so much for me." The room was silent. John, Mike, and Steve exchanged glances, indicated that they understood. I said, "*I see you guys nodding your heads. You know exactly what Jack is talking about?*"

Steve nodded yes and said, "I feel the same way." He looked at Jack and said, "I identify with you totally. I am so angry at my parents, but it is hard for me to be mad at them because they are doing so much for me, you know what I mean. I can't help it though. Whenever I am at home there is all this tension, and I know I am the cause of it. You know what I mean?" I asked, "*What do you think the tension is about, Steve?*" He answered, "I don't know, I mean, I guess I am tense because they don't really accept me. Like sometimes when we are all at home and watching some TV, a show comes on and there is the token gay character. You know what I mean?" We all laughed knowingly. Steve continued, "Well I always try to bring it up and talk about it. But they won't discuss it. I really try to talk about it, but they just won't. It's crazy. It's as if a wall comes down [*Steve placed his hands out as if he was making a wall*]. Sometimes, I push a little, but then they get really tense; so I stop. It makes me mad. I mean as far as the gay thing. Like, OK, so I am gay, but it's not like it's the end of the world. You know what I mean?" "*Yes, it really hurts not to have your parents accept who you are,*" I replied. Steve continued, "After I graduate, I am going to move into the city and be on my own and I won't have to deal with them."

Mike replied, "My parents are great, they really are, but I am mad at them, too. I treat them like shit. They have always been there for me, even when my lover died, and everything. I don't know why, but I am just a total bitch to them." I asked Mike, "*Any hunches what makes you so mad at them?*" "I don't know," he said. "I really don't. I can't help it. Do you know?" With that question all the members looked at me. I said, "*I am not sure, but on the one hand you are appreciative of the help your parents give you, but, on the other hand, you all feel different levels of acceptance about who you are, ranging from mild disappointment to total rejection.*" John agreed, "My parents pay for my apartment, my tuition, my living expenses, but I am not allowed to talk about being gay. It's a nonsecret

secret!” “Yeah,” Jack added, “In order to afford school, I had to live with my parents, and they are financially generous with me, but not in their acceptance of who I am—I always see the disappointment and hurt in their eyes.” After a silence, I added, “*You know most guys your age go through a rough time separating from their parents, but being gay makes it much tougher, much more confusing. We grow up having our parents love us and then they find out we are gay and we become someone else. We are no longer the child they used to play with, protect, embrace. Their son is gay and for some, at least initially, they experience it as a terrible loss—a loss of their hopes and dreams. And we discover that some of their love is conditional. And then we too feel a powerful loss. What is it like for you when your parents make you feel that you are not the son they had hoped for?*”

Mike said, “It’s awful—the pain shoots throughout my body.” He looked down at the floor.

John said, with tears welling in his eyes, “Terrible doesn’t describe it—especially with my Mom. We used to be so close before I told her, and now she treats me as if I don’t exist.” A painful silence followed. Steve and Jack began to cry. Steve looked at me and said, “It really hurts, you know what I mean?” I said, “*I do know, Steve, I know what you mean and I know how it feels.*” John said, “I miss my Mom so much. She used to play with me and love me. It’s really strange. She always had gay friends, but when it came to me, she couldn’t accept it. Things have never been the same.” John continued to wipe away his tears and asked me, “Does it ever get better?” I said, “*Yes, it does get better—we all find ways to heal. But what I worry most about is that you guys are acting out your pain in very self-destructive ways—like punishing yourself through unsafe sex—like my parents don’t care about me, so why should I care about myself.*”

Steve responded, “You know right now I feel better than I have in a long time, I really do.”

John and Jack replied, “Me too! I am not alone with this pain.” Mike agreed, “I feel much clearer—I didn’t hear any of your lectures on safe sex. Today I heard you that you cared about me—about us.”

This brief practice vignette poignantly illustrates some of the previously discussed mutual aid processes. Members share relevant facts and feelings, particularly about the complexity of their relationships to their parents and their profound feelings of rejection. For adults to express the devastating pain, alienation, and wounds from parental rebuff and their need for continued parental love and support opened the door for discussion of other taboos. Group members discover that they are not alone with their intense feelings and thoughts and experience the “all-in-the-same-boat” phenomenon. This experience expands their perspectives and helps them to externalize and universalize their life issues. Mutual support fuels their work. In subsequent meetings, they examine their self-destructive behaviors, confront avoidance and denial, engage in problem solving, and use role play to rehearse new behaviors.

As a gay man, the intern easily identifies with the suffering of these young adults. He has been there, walked in their shoes. He recognizes that they have been alone with their pain, alone in their transition from being gay adolescents to being gay young adults. Previously, they had confronted a tormenting dilemma: namely, to remain in or out of the closet in relation to their family members. If they decided to be true to themselves and their identity, they would inflict pain on those they loved. In sharing their sexuality, they probably received reactions from their parents that ranged from identifying their son’s behavior as immoral and sinful to declaring that their son had a disease that needed to be treated to a milder view of a slight sexual imperfection and abnormality. At best, the members experienced reactions of hurt and disappointment and, at worst, rejection and abandonment.

These youngsters were adrift without essential supports and adult gay role models. The student helped them to find each other, and he served as an important gay adult role model who understood and accepted their realities. They had been previously exposed to safe-sex education but were unable to incorporate the information into their lives. As they explored their developmental pain, they began to make connections between unsafe sex and their low self-esteem and their search for love and acceptance. As one member explained his participation in unprotected sex, "I was afraid he wouldn't like me, and that he would ask me to leave." These youngsters internalized the dominant culture's oppression of homosexuals and turned the rage against themselves.

Providing information on safe sex, although important, is clearly not sufficient. How do we help gay and lesbian group members struggle with the existential question of "Who am I?" if their most loved ones do not know who they are, choose to act as if they are not who they are, or know but do not accept who they are? The group members must experience the worker's genuine caring and acceptance; otherwise, the worker's actions will seem to be a mechanical effort removed from the realities of their lives. Added to professional caring, the worker must have skills in group processes. For members to examine their risk-taking behavior and to consider changing these behaviors, the worker has to harness the constructive and healing power of mutual aid. Information combined with mutual aid might prevent much future suffering.

CONCLUSION

In conclusion, this chapter describes the historic context for the mutual aid model. Using the social goals philosophical and value base, Schwartz developed a distinct conception of social work function and an approach to group practice that emphasized the intrinsic value of mutual aid. He conceptualized phases of helping to describe a professional methodology. Others have added to the foundation he established by further specifying and illustrating mutual aid at work.

In contemporary practice, mutual aid is an essential process, whatever theoretical base is used. Mutual aid is provided to various vulnerable and resilient populations, such as people dealing with traumatic experiences (Clemans, 2005; Knight, 2006); grief (Knight & Gitterman, 2014); and AIDS (Amelio, 1993; Anderson & Shaw, 1994; Antle, 2002; De Ridder & Witte, 1999; Edell, 1998; Getzel, 1994, 1996; Getzel & Mahony, 1993; Hayes, McConnell, Nardozi, & Mullican, 1998; Heckman et al., 1999; Meier, Galinsky, & Rounds, 1995; Pomeroy et al., 1997; Rittner & Hammons, 1992; Saporito, 2001; Subramanian, Hernandez, & Martinez, 1996); people with mental health difficulties (Bronwyn, 2013; Partington, Gee, Leith, & Croucher, 2012) and in health care settings (Keast, 2012); people with alternative sexual orientation (Galassi, 1991; Marrow, 1996; Peters, 1997; Saporito, 2001; Saulnier, 1997; Turrell & de St. Aubin, 1995); immigrants and refugees (Berger, 1999; Breton, 1999; Feinberg, 1996; Lin Hung, 2012; Lopez, 1991; Marsiglia, 2010); people contending with intimate partner and other violence (Damant et al., 2010; Gregory & Erez, 2002; Letendre & Williams, 2014); sexual abuse (de Jong & Gorey, 1996; Roe-Sepowitz, 2014; Schiller & Zimmer, 1994; Trimble, 1994; Tutty et al., 2001); homelessness (Brown, 1994; Cohen, 1994; Lee, 1994); and older elderly people and their caregivers (Berman-Rossi, 1994; Brennan, Downes, & Nadler, 1996; Gottlieb, 2000; Kelly, 1999; Kelly & Berman-Rossi, 1999; Orr, 1994; Poole, 1999; Sistler & Washington, 1999). Mutual aid continues to be at the core of social action groups (Breton, 2012; Cohen & Mullender,

1999; Cox, 1991; Gitterman, 2003b; Gutiérrez & Lewis, 1999; Mullender & Ward, 1991; Naparstek, 1999; Sullivan, Goodman, Lang, Mesbur, & Mitchell, 2003). For isolated and physically and emotionally challenged group members, mutual aid groups are offered via the Internet and telephone (Bowman & Bowman, 1998; Heckman et al., 1999; Kaslyn, 1999; Meier, 1997; Meier et al., 1995; Rittner & Hammons, 1992; Rounds, Galinsky, & Stevens, 1991; Schopler, Galinsky, & Abell, 1997; Weiner, 1998) and in curriculum groups (Galinsky, Terzian & Fraser, 2006; Letendre, 2007; Letendre & Wayne, 2008). The concept of mutual aid has also been applied to education (Berman-Rossi & Gitterman, 2003; Gitterman, 2004, 2009; Shulman, 1970).

Until recently, mutual aid processes have received insufficient empirical attention. In a review of 54 studies, for example, Tolman and Molidor (1994) found that cognitive-behavioral groups dominated the research literature. Only four studies systematically measured any aspect of group process. Although several studies acknowledged the importance of group process, “only two attempted statistical analyses to examine the impact of small group differences” (p. 155). More recently, mutual aid processes are being studied in various fields of practice. In the area of sexual abuse, for example, Gorey, Richter, and Snider (2001) explored the impact of group work intervention on female survivors’ feelings of guiltlessness, affiliation, and hopefulness. In the area of HIV/AIDS, Pomeroy and colleagues (1997) studied a 6-week psychoeducational group intervention to alleviate stress, depression, and anxiety. In the area of corrections, Springer, Lynch, and Rubin (2000) studied the impact of a mutual aid group intervention for children of incarcerated parents. In the area of intimate partner abuse, Tutty and colleagues (2001) evaluated 15 treatment groups for male batterers; Pandya and Gingerich (2002) provided a microethnographic study of a group intervention for male batterers; and Pepler and colleagues (2000) evaluated a peer counseling program for children exposed to domestic violence. In gerontology, Gottlieb (2000) reviewed the literature on process and outcomes of health-related self-help and support groups for older adults. In future studies, researchers could use, for example, Macgowan’s (2000; Macgowan & Newman, 2005) measure of members’ engagement in the group process. The measure offers potential for more effective examination of mutual aid processes.

A significant challenge for the mutual aid model is the lack of group work education in schools of social work. Social work students receive limited exposure to group work theory, methods, and skills related to forming groups, contracting, supporting mutual aid in phases of group life, building mutual aid group structures and cultures, and dealing with blocks to mutual aid. Without sufficient exposure to group work history, theory, and practice traditions of commitment to democratic values of partnership, mutuality, and social justice, graduates do not fully appreciate the potential of mutual aid and lack sufficient group work skills (Kurland & Salmon, 2002). Thus what remains unclear is where the future educators, administrators, practitioners, and researchers will learn the art and science of mutual aid processes. The International Association for the Advancement of Social Work with Groups (www.iaaswg.org) is attempting to ensure the survival and growth of social group work practice.

NOTE

1. Schwartz (1961) acknowledges Kropotkin (1925), Mead (1934), Sherif (1936), and Murphy (1958) for providing the rationale for the symbiotic perspective.

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CHAPTER 8

Cognitive-Behavioral Group Work

RICHARD TOLMAN
CRAIG W. LECROY

Cognitive-behavioral group work is composed of various approaches that include group processes based on small-group theory, cognitive and behavioral strategies, and evidence-based group interventions. There are many basic overlapping theories inherent in the therapeutic paradigm presented in this chapter. First, cognitive-behavioral group work makes use of a small-group theory insofar as it takes advantage of the unique characteristics and curative factors assumed to be inherent in small-group processes. Consistent with this orientation, the paradigm draws heavily on research on small groups and small-group therapy for making decisions about treatment planning and interventions. Second, the approach draws on group processes that reflect motivational theory, since the early phase of treatment is devoted to enhancing the motivation of the participants. Third, cognitive-behavioral interactive group therapy is governed by a variety of cognitive-behavioral procedures; for example, new behaviors and cognitions are learned in the service of resolving problematic situations. Fourth, cognitive-behavioral group therapy is goal oriented. Both individual treatment and common treatment goals are developed for and by each client, and group goals are formulated concerning group conditions requiring change. Fifth, cognitive-behavioral interactive group therapy has an empirical orientation. Because the method has access to most intervention procedures and many theories, the group practitioner is encouraged to show a preference for techniques and strategies for which empirical support exists. These elements form the theoretical foundation of the cognitive-behavioral group work approach.

Cognitive-behavioral group therapy is recognized as being as effective as individual therapy in treating a wide range of difficulties (Burlingame, Fuhrman, & Johnson, 2004; Markus & King, 2003). For example, a recent meta-analysis of randomized control trials for depression found that different types of group therapy were effective in reducing depression (see McDermut, Miller, & Brown, 2001). Many reviews of the effectiveness of

This chapter is based on the original writing and ideas of Dr. Sheldon D. Rose, who passed away in 2010. This chapter draws heavily upon his chapter in the first edition of this book (Rose, 2004).

cognitive-behavioral group therapy can be found when searching on specific diagnostic groups (e.g., anxiety, PTSD, obsessive-compulsive disorder). Perhaps most significant is that cognitive-behavioral therapy in a group format has consistently been found to be a cost-effective alternative to the provision of individually based treatment (Tucker & Oei, 2007; Vos, Corry, Haby, Carter, & Andrews, 2005). A recent study by Thimm and Antonsen (2014) found that group cognitive-behavioral therapy in routine care found a 44% improvement in symptoms. While difficult to summarize because of the various diagnostic groups, many studies have found positive outcomes with cognitive-behavioral therapy when compared with individual therapy.

One of the clear advantages to group work is that clients work *together*, and the experience of being together for a mutual purpose is itself an important therapeutic factor. An important group leader skill is being able to encourage group members to help each other. Other advantages include group members as a source of feedback and modeling. And group members can obtain a sense of social support that is often needed to encourage new behavior changes. The group setting is interactive and real and often becomes an environment that mimics issues in the real world. This provides the group leader with information that can help bring about new awareness and understanding and opportunities to try different ways of thinking or behaving.

Furthermore, group-based therapy may be the treatment of choice depending on the nature of the problem being treated. In particular, a group-based model may be ideally suited for individuals with multiple behavior problems and who experience some “rigidity” regarding their orientation to change (Shaffer, 1976). An additional advantage of group work is that program models are frequently developed for groups and provide a well-defined and manualized set of guidelines for the practitioner. For example, there are group manuals for depression, social skills training, trauma, divorce, substance abuse, and others (see LeCroy, 2008). Figure 8.1 summarizes the key advantages of working with groups from a cognitive-behavioral perspective.

EMPIRICAL ORIENTATION

Cognitive-behavioral interactive group therapy can be identified as having an empirical orientation insofar as available research on group therapy or any of the target behaviors,

- Promotes mutual understanding and “universality” between members.
- Is cost-effective and efficient treatment strategy.
- Can be implemented with clear guidelines following a group treatment manual.
- Promotes altruism and cohesion among group members.
- Strengthens the social support and reinforcement that members can obtain from each other.
- Provides feedback that can reflect “real-life” issues.
- Provides an interpersonal context that can facilitate learning skills.
- Provides models and rehearsal opportunities for group members.

FIGURE 8.1. Advantages of the group.

target populations, or interventions is incorporated into goal setting and treatment planning. Moreover, data are collected throughout therapy for determining whether and what kind of groups a person should be in, what the specific foci of therapy should be, and what interventions should be initiated. Group data are also used in making ongoing clinical decisions, in determining group problems, and in evaluating the effectiveness of therapy.

STRATEGIES FOR EFFECTIVE GROUP INTERVENTION

In order to provide a better sense of how the group is conducted, we review some of the key group strategies for effective treatment. These include building group cohesion, identifying and correcting group problems and using effective group interventions, and using individual treatment procedures in a way that is compatible with a group environment (Rose, 2004).

Beginning the Group

The beginning of the group is critical in establishing how the group will function and in setting the expectations, norms, and structure of the group. Clients often join the group reluctantly and with trepidation. Group leaders must recognize this and help individual clients become comfortable and see benefit in how the group can help them. Skilled group leaders recognize that they should simultaneously work with individual clients and also work with the group as a client. They want to engage the clients and help facilitate the group development. Figure 8.2 lists some core skills that group leaders should exemplify.

Building Group Cohesion

Group therapy research has supported the principle of group cohesion as an effective ingredient of group treatment (Burlingame, McClendon, & Alonso, 2011; Rose, 1989). Strategies to promote cohesion in groups are underutilized, even though the research points to a strong association between client improvement and group cohesion. Cohesion refers to the mutual liking of members for each other and the group leader and their attraction to the program or process of the group. Research suggests that high cohesion is correlated with increased motivation to engage in behavior change (Burlingame et al., 2011). Building cohesion in groups is an important skill that can help group members increase motivation and enhance compliance with group tasks. One easy way of increasing group cohesion is through the use of introductory exercises; for example, group members interview each other in pairs and then

- Help group members understand the group's purpose.
- Promote mutual support and "universality" among members.
- Help members perceive commonality between themselves and others.
- Facilitate positive interaction between group members.
- Express understanding and empathy toward members.
- Encourage members to "take risks" and help them verbalize their concerns.

FIGURE 8.2. Core skills needed when starting a group.

introduce their partner to the group. This promotes a beginning level of self-disclosure and begins the process of building cohesion. With children and youth, the use of recreational games or other activities at the end of a session can increase the cohesion of the group (Rose, 2004). In general, cohesion is enlarged by creating opportunities for member-to-member participation, eliminating or reducing any confrontation or conflict in the group, keeping the communication positive, using variation in the program, and facilitating decision making by the members. Also, cohesion is developed when group members provide feedback to each other in exercises or rehearsals.

Motivational Enhancement

In group work, motivational enhancement is important because many clients enter treatment with some degree of reluctance. Often, they do not want to be seen as having problems, being weak, or needing help. Because of these concerns, they are often not motivated to begin the difficult work of confronting their problems. These issues are compounded when groups include involuntary clients, such as offenders or mandated drug users. In most change-oriented opportunities, clients approach the situation with ambivalence. Examples of such barriers to participation include denial of the seriousness of their problems, anger about being in treatment, lack of interest in expressing themselves, reluctance to develop individual goals, and lack of participation in extragroup processes such as additional learning tasks outside of the group.

The goal of motivational enhancement is to improve the readiness of the client to fully engage in the group treatment experience. This model of behavior group therapy considers motivation to be essential for planning and achieving treatment goals. A primary goal for the group leader to consider is how to enhance client motivation in group treatment. Strategies for improving motivation should be implemented throughout the phases of group treatment to maintain the client's commitment to change.

Assessment

Assessment begins in the pregroup and intake phases of treatment. Often practitioners will administer some type of outcome assessment measure to examine individual-level changes on the part of the client. In this context, many paper-and-pencil measures can be used for assessment, such as the Social Functioning Scale (Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990), Children's Hope Scale (Snyder, Hoza, Pelham, & Rapoff, 1997), Hamilton Anxiety Scale (Riskind, Beck, Brown, & Steer, 1987), or the Brief Resilient Coping Scale (Sinclair & Wallston, 2004). Many sources exist for identifying different clinical outcome instruments. This assessment can be used to examine client change from pregroup involvement to postgroup or to a follow-up time period.

Assessment is also conducted to examine the group process. In this manner data are collected from individuals about their group experience, typically with a postsession questionnaire (Rose, 2004). Participants are asked to rate some aspect of the group session on a scale from 1 (not at all) to 9 (extremely). The group leader can formulate relevant questions. Typically about 6–12 questions are used. Examples of questions include: "How useful was this session?"; "How helpful were the members to each other during the session?"; and "How upset or angry were the members during this session?" These data can be reviewed by the group leader to obtain a sense of how the group is functioning and how the members perceive it. Information obtained from this assessment is then discussed at the beginning of

the next session. For example, if there is a lot of discrepancy in the items between members, then this can be addressed with the group. This information provides a structure by which the group leader can address group norms in a routine manner.

Goal Orientation

Individual clients come to therapy with problems and concerns. (Some of the specific concerns clients might bring into a behavior therapy group are listed in Figure 8.3). Individual clients work toward developing specific treatment goals in the behavior group therapy approach. The targets for change are most typically a specific behavior or cognition. This process is helpful because it moves clients from negative and vague descriptions of problems to a more positive outcome-oriented language of goals. A goal is a clear statement that a person has committed to act upon. It is recommended that goals be SMART: Specific, Measurable, Action-oriented, Realistic, and Timed. The group leader will help bridge goals across members and emphasize the commonality of the individualized goals. Sometimes group members help other members in developing and refining their goals.

Group goals are directed specifically toward what happens within the group. For example, a group goal might be that all members equally participate by the end of the group session or that all members will have completed at least one role play. Group goals are designed to help the members recognize that the group process is an important part of what they experience as individuals. For example, if the group goal is to enhance cohesion, this will likely affect individual client improvement. The group leader typically proposes group goals to the group. For example, in an anxiety group in which the group problem was that members would rarely provide each other with feedback, the group goal was to increase the feedback given to each other. This goal would enhance the members' learning of the skills they needed if the goal was achieved.

Addressing Group Problems

A recent study (Macgowan, 2012) examined group leaders' perceptions of the most difficult skills to implement in group work. The top three items included: developing skills in working with mandated or involuntary clients; exploring troublesome norms when they emerge; and addressing conflict in the group. Being an effective group work leader is a challenging endeavor. It requires training, practice, feedback, and supervision. Too often group leaders do not have access to training opportunities to build these skills. Ironically, when implementation science is being recognized as critical, there has not been a similar focus on group

- The client is being excessively criticized by her spouse.
- The client is in difficult situations with friends.
- The client does not know how to solve a problem at work.
- The client is afraid to express her opinions to others.
- When the client is alone, she becomes lonely and depressed.
- The client perceives that she is being criticized by her spouse.

FIGURE 8.3. Examples of client concerns.

work training. Groups will likely continue as an important modality of treatment. Figure 8.4 highlights some of the advanced group leader skills necessary for effective group work.

Some of the most common problems in group work are inattentiveness, low cohesiveness, and uneven distribution of participation. The use of group exercises and self-disclosure can be used to increase cohesion and address some of these problems (Rose, 1989). As members come to like and trust others in the group, they are increasingly willing to share with others their conflicts, their goals, their levels of motivation, and their appraisal of problematic events and to accept feedback and suggestions.

Group exercises refer to the use of structured interactive activities as ways of teaching clients the skills that mediate the achievement of therapeutic goals. For example, an introduction exercise is used in which a client interviews and is interviewed by at least one other member of the group and then introduces the partner to the others. Another exercise is one in which the clients study a case and discuss how each of them is similar to or different from the person in that case. Other exercises involve teaching clients how to give and receive both praise and criticism to a partner in the group. Exercises, to be effective, are usually in writing, and the goals, as well as the activities, are stated explicitly. The group worker should take care that the exercise is understood before it is implemented. Other interventions, in addition to subgrouping, may be embedded within group exercises. For instance, a “round robin” exercise uses modeling and rehearsal at a fast clip in order to provide multiple trials of new behavior. In teaching how to ask for help, Steve asks Janice for help, then Janice asks Ray for help, then Ray asks Stan for help, and, finally, Stan asks Ron for help. Extensive examples of cognitive-behavioral group work exercises may be found in Rose (1989).

INTERVENTIONS

Cognitive-behavioral group work (CBGW) is a multifaceted, multimodal set of intervention procedures. Some of these are disorder- and problem-specific. We focus here on a core set of interventions that are common to many issues/problems/disorders addressed by CBGW. Although they are not unique to groups, because they may be implemented individually as well, nor unique to CBGW, because they have been adopted or adapted from other

- Use advanced planning, set agendas for each session.
- Encourage member-to-member interaction and support.
- Keep the group focused on the objective or theme for each session.
- Express empathy and model positive feedback.
- Link common problems to individual client situations.
- Teach specific skills or cognitions using modeling, rehearsal, and feedback.
- Encourage active participation in all group activities.
- Balance structure with responsiveness to group needs.
- Manage common group problems: lack of interest, monopolizing, hostility, resistance.
- Summarize progress and keep the group motivated.

FIGURE 8.4. Group leadership skills.

approaches, they constitute a core set of interventions identifiable as CBGW. Here we focus on aspects of the interventions most applicable to a group application.

Problem Solving

In CBGW, problem solving consists of specified steps that include: orienting the members to the basic assumptions of problem solving, identifying and defining the problem and client resources for dealing with the problem, generating alternative solutions, evaluating and selecting the best set of solutions, preparing for implementation, implementing the solution outside the group, and evaluating the outcome with the other group members at a subsequent session. In this preparation for implementation stage, modeling, cognitive restructuring, or information giving may be used to prepare a group member to implement his or her chosen solution outside the group, and an extragroup task is designed to be carried out prior to the next session. At times, the tasks may involve small and gradually increasingly difficult steps toward performing the goal behavior. For example, Jerry is a college student who was arrested for driving under the influence and has been referred to a group to learn about responsible drinking. She has identified a goal of wanting to stop binge drinking and improve her academic work, which she acknowledges has suffered because of her partying and heavy drinking. She tells the group her roommate keeps asking her to go out drinking with her, even when she is trying to study.

JEFF: Just tell her you don't want to go.

JERRY: I do, but she is really persistent. She never wants to take no for an answer. She wears me down.

WORKER: Jerry, how do you feel about asking the group for some brainstorming for what you could do?

JERRY: Sure.

WORKER: OK, group, everyone write down an idea about what Jerry could do.

(The group writes down various suggestions.) Ready? Let's go around and share them. Remember, at this point, let's not critique the ideas, just share them *(brainstorming)*. Jerry, you take some notes on the ideas that you hear.

JIM: You could move out. Get a roommate who isn't so crunked all the time.

JOHN: Why should she have to move out? It's her roommate that's the problem.

WORKER: Remember, we aren't evaluating at this point. Just sharing ideas. Who else?

KAREN: Tell her you will go out with her another time, when you don't have to study.

JUANITA: You could talk with her and ask her to let up. Does she know what you are trying to do, how you are trying to change?

DALE: Try studying at the library instead of your room. Then she won't be able to bug you so much.

MARY: You could do a couple of shots and get back to studying. *(Laughs)*

WORKER: I am assuming that one was just for purpose of brainstorming, Mary. OK, Jerry, you have heard some suggestions. Let's go over the pros and cons of each one.

In the discussion, Elizabeth shared that one of her friends was supportive when she told them she was trying to cut down on drinking, which provided some support for Juanita's suggestion that Jerry tell her roommate about why her offers to party weren't welcomed. Jerry decided she would give that a try.

Systematic problem solving in groups can be an effective group procedure because group members are a rich resource for generating potential solutions. When examining potential solutions, group members provide varied life experiences on which to support or reject some of the solutions generated. Group members can provide each other with support for carrying out the task.

Some other behavioral procedures share elements with problem solving. For example, in a depression group, to promote behavioral activation, members may share activities that they have found pleasurable in the past, that they currently find pleasurable, and that they may want to try. This group sharing serves as a brainstorming process in which members identify novel, as well as previously used, activities to try out. The group may then assist each other in planning the implementation of the behavioral activation strategies.

Modeling and Behavioral Rehearsal

Social learning theory posits that people learn from observing others, and this type of social modeling can be a core process in many types of groups. Group workers and group members may all be sources of modeling. Modeling can be an explicit formal process, or it may occur informally in the group as members share how they deal with problematic situations. Because of the presence of many potential models and sources of feedback, modeling is especially useful in groups.

Modeling in CBGW often involves simulated demonstrations (role playing) by group members and/or the group worker. Modeling may also include video, audio, or textual demonstrations to present a given behavior or a set of behaviors or interactive solutions to problematic situations. In CBGW groups, a typical sequence would be for a behavior to be modeled, either by the group worker or a member, and then rehearsed in the group. The group worker can direct the action so that successful behaviors can be reinforced and unsuccessful ones terminated and redeveloped. Group members can provide meaningful situations in which to provide modeled behaviors and support the development and implementation of those behaviors by its members.

The small group is especially well suited to the use of modeling, as it affords a rich source of ideas as to what the model should do and multiple sources of feedback. Also, when members model for each other, especially in conditions of high cohesion and universality, the acquisition of the modeled behavior is enhanced. Behaviors are more likely to be repeated when modeled by someone the observer perceives to be similar to him or her.

Modeling and behavioral rehearsal may be used as a major interventional package. The steps we have used for modeling and behavioral rehearsal are included in Figure 8.5.

In the previous example, after problem solving, Jerry decided she was going to talk to her roommate about letting up on pressure to go drinking. The group worker suggested a behavioral rehearsal so Jerry could practice having that conversation in the group session. The group agreed that this was something that a lot of them could benefit from. Jerry picked Elizabeth, who had shared that she had previously successfully talked to a friend, to model what she might say. Jerry played her roommate who is pressuring her. After hearing how Elizabeth handled it, Jerry gave it a try, with another member playing her roommate. The rest of the group watched and then gave feedback on how well Jerry did, first positive

- The group worker orients the group to modeling and demonstrates the modeling steps (first few times only).
- Based on a situational analysis of an interactive situation, each client—one at time—presents a situation for which he or she wants to have his or her behavior modeled. The member clarifies the roles of model, target person, significant others, and observers.
- A model is selected who demonstrates the desired behaviors. The model may be the group worker or a group member.
- The target person rehearses or practices what he or she observed and, if necessary, with some coaching or assistance from others (rehearsal plus coaching). If coaching is used, the rehearsal is repeated without coaching.
- The target person is provided with feedback from the other group members and the group worker.
- The practice is repeated as many times as time permits until the target person is comfortable in his or her new set of behaviors. If necessary, additional practice may be carried out in pairs or triads within the group to save time or as extragroup task partners.
- With the assistance of the group or a partner, each client designs an extragroup task to perform the modeled behavior in the real world or to practice again outside of the group.

FIGURE 8.5. Steps for modeling and behavioral rehearsal about here.

feedback and then what she could do to improve. She tried it again, incorporating their feedback. Jerry then agreed to try to have this conversation during the next week and report back to the group on how it went.

Cognitive Change Methods

Cognitive change methods, first developed by Aaron Beck (Beck, Rush, Shaw, & Emery, 1979), are the “C” in CBGW. Bieling, McCabe, and Antony (2006) describe four types of cognitive techniques that are used in groups: (1) connecting thoughts to situations and affect; (2) use of evidence gathering and thought distortions; (3) cognitive experiments; and (4) exploring underlying beliefs and assumptions. The process of cognitive change often begins with first helping clients make a connection between their thoughts, assumptions, or beliefs in situations and how they feel and behave. Group members learn to identify thoughts that may lead to negative emotions and to replace those thoughts with ones that are less likely to evoke strong negative emotions. This process of examining thoughts for distortions or errors in thinking is not meant to be a confrontational process, but rather one in which there is a shared process of investigating thoughts and their impact. In groups, the group worker and the group members share this exploration. This shared responsibility makes it critical that group members learn, through modeling and feedback of the group worker, how to ask each other questions and give feedback to each other to foster new perspectives.

One tool commonly used in cognitive restructuring is a list of cognitive distortions or thinking errors that can lead to a more negative emotional response to a situation. By learning about these common distortions, group members can begin to identify thoughts they have that might contain these distortions. The exercise in Figure 8.6 contains a list and definitions of some of these common distortions, including mind reading, prophesizing the future, catastrophizing consequence, overgeneralizing, and making absolute judgments.

Rationale

Most clients make statements about themselves that are illogical, self-defeating, and distorted. These distortions often lead to anxiety, stress, depression, and anger. Much of treatment, regardless of its theoretical orientation, is aimed at correcting these distortions and replacing them with more functional evaluations, thoughts, or self-statements. There are many strategies for accomplishing this. Based on the work of Meichenbaum (1977), this exercise represents a direct way of identifying those statements regarded as self-defeating and then replacing them with coping or self-enhancing statements. Most statements that are self-defeating meet several of the following criteria:

1. Does the person make an *absolute* judgment of him- or herself? (e.g., *never, can't, always, won't, should, shouldn't*)
2. Does the person need to *mind read* the thoughts of others to make the statement?
3. Does the person grossly *exaggerate* the conditions that are referred to in the statement?
4. Does the person make a *catastrophe* out of a difficult or uncomfortable situation?
5. Does the person leap to *conclusions* about him- or herself or situation without adequate evidence?
6. Does the person *overgeneralize* from one set of circumstances?
7. Does the person *put* him or herself *down*, or is the person overly critical of him or herself?
8. Does the person *disregard* important aspects of situations while emphasizing other, more negative aspects?
9. Does the person *prophesy* the future without evidence?

The criteria for identifying coping or self-enhancing statements are the following (not all the criteria need be met):

1. Is the statement *realistic*, not overly optimistic or “Pollyannaish”?
2. Is the statement *positive* in content and intent?
3. Is the statement *instructive*? Is it guiding a behavior or set of behaviors?
4. Is the statement *appropriate* to the situation?
5. Is the statement *anxiety reducing*, and/or does it *reduce expectation of threat*?
6. Is the statement free of *self-defeating* elements? (See criteria for evaluating self-defeating statements.)

Purpose of the Exercise

By the end of this exercise, the participant will have:

1. Identified his or her own most commonly used self-defeating statements and the conditions under which they occur.
2. Identified more appropriate alternative self-enhancing or coping statements to replace the self-defeating statements.
3. Differentiated among self-defeating statements and other statements indicating behavioral deficits or other behavioral problems.
4. Identified at least five conceptual reasons why his or her own or the self-defeating statements of others are self-defeating.
5. Demonstrated how to change self-defeating statements into more appropriate self-enhancing ones.

(continued)

FIGURE 8.6. Identifying self-defeating and coping statements.

Individual Task 1

In the following statements, each participant should identify which are self-defeating and which are self-enhancing statements. Indicate why a statement is self-defeating according to the criteria discussed in the “Rationale” of this exercise. Each participant should change the self-defeating statement to a coping statement by drawing upon the list of coping statements above (15 minutes or homework).

1. “I’ll never be able to get that job, even if I am qualified.”
2. “How can I ever have a decent interview when I know she (the interviewer) won’t like me?”
3. “Sure, it’s complex, but what I can do is to take one thing at a time.”
4. “I know I’m going to blow it with all those people looking at me.”
5. “He (she) must really think I’m stupid.”
6. “What if they think I’m imposing? Maybe I’m just wasting their time. I better not ask to see them.”
7. “Why bother to ask her out? She probably won’t like me anyway.”
8. “I may not get the job, but I’ll do my best in the interview.”
9. “It doesn’t matter how hard I work, it will be just my luck to fail.”
10. “Sure it’s going to be a tough week, but if I plan my time well, I can get through it.”
11. “It’s been such a hectic day. I know I won’t be able to sleep.”
12. They’ll think I’m weird if I wear that sweater to the affair. No one will even talk to me.”

Group Task 1

The group is divided into subgroups of four to five persons who will compare their responses in the above exercise. (Use criteria in the “Rationale” to evaluate whether a statement is self-defeating.) (30 minutes)

Individual Task 2

Participants should add one self-defeating statement to the list that each has heard from a friend or client. (5 minutes)

Group Task 2

Participants will present their own self-defeating statement to the subgroup. Other members of the group will first give reasons why statements are self-defeating and carefully distinguish between self-defeating statements and statements of fact. Then the group should brainstorm alternative coping or self-enhancing statements. (40 minutes)

FIGURE 8.6. *(continued)*

Another tool frequently used in cognitive restructuring is the “thought record.” The thought record is a form, usually divided into multiple columns (ranging from three to seven), that is used to monitor and challenge thoughts associated with negative affect. Here we present an example of the use of a seven-column format available online (*Psychology. tools*, 2016). This form includes columns for: (1) Description of the situation; (2) emotion or feeling in the situation (rated 0–100%); (3) automatic thoughts or images; (4) evidence that supports the automatic thought; (5) evidence that does not support the automatic thought; (6) alternative thought (that takes into account evidence for and against); (7) emotions or feelings now (in light of alternative thought, rated 0–100%).

In the group setting, members can be introduced to the form, and then each member completes an example during a group session. In subsequent sessions, group members report

on their thought records. In filling out a thought record in a group for social anxiety, Randy discussed a date he was on. His responses were: in column 1, Situation: “On a first date with someone a good friend fixed me up with.” Column 2, Feelings and emotions: “Anxious—90, Incompetent—80.” Column 3, Automatic thoughts: “She thinks I am a loser”; “She will notice I am sweating and falling apart”; “She will never want to go out with me again.”

WORKER: (*Writes Randy's responses on a white board.*) Let's help Randy examine this situation and his thoughts. First, look at his thoughts? Does anyone notice any of the thinking filters we discussed?

DARALD: “She thinks I am a loser” seems like mind reading.

HEESUK: “She will never go out with me again”—that's predicting the future.

MARTIN: Or maybe that's kind of catastrophizing, too.

WORKER: Right. Sometimes automatic thoughts can fit more than one category. It's not so much what category it fits but whether it's accurate or helpful. Let's work on that next. Randy, before we move on, do you think these categories fit?

RANDY: Yeah, they do. “She will notice I am sweating”—that's kind of mind reading, too.

WORKER: Rock star on that—another mind read. Which of those thoughts should we work on first? Helps to focus on just one, maybe the one that's leading to the most negative emotion.

RANDY: I am not sure—maybe “She thinks I am a loser.”

WORKER: First, let's make a tweak to that. Did thinking she thought you were a loser make you think you “I am a loser?”

RANDY: Yeah, for sure.

WORKER: Let's look at the evidence, for and against, for that thought: “I am a loser.”

After working with the group, Randy's answers in column 4, Evidence for the thought, included “I was nervous the whole time”; “I sweated a lot”; “I needed a friend to fix me up”; “I had a hard time coming up with things to say.” The group helps Randy generate some evidence against the thought for column 5 because he has a hard time initially doing that.

CHOY: Hey, you have friends that want to fix you up. That's evidence against you being a loser.

WORKER: Good point, Choy, and good work supporting Randy on this. Who else has some ideas about the evidence?

DARALD: Who isn't nervous the first time they go out with someone? That doesn't make you a loser. It makes you a human.

HEESUK: Dude, you went out with her, even though you were scared. That's huge.

With the group's help, Randy's answer in column 6: Alternative thought, was: “Being nervous on a date doesn't make you a loser. I can't know in advance if someone is going to like me. It's really good I went on a date and gave it a try.” Column 7: Emotion and feeling had “Nervous—60, Incompetent—50.”

This example raises some issues. The worker's tweak of Randy's thought focused the work on Randy, rather than on speculation about evidence for what his date thought. The latter is less likely to be productive. A second point is that "incompetent" may not be a feeling but rather a belief about oneself. The worker chose not to focus on that but might have followed up by asking about what feeling Randy has when he thinks or tells himself that he is incompetent. The example demonstrates how the group can provide ideas and support. The members of this group, as is often the case, were better at recognizing and challenging the distortions of other group members than their own. This not only provides practice for challenging thoughts they themselves might have but also demonstrates how altruism, or helping others, is a valuable aspect of group process. Another type of cognitive restructuring that we employ frequently (Rose, 1989) is characterized by a set of procedures used to improve cognitive coping skills by recognizing thinking errors and replacing them with coping thoughts. One exercise we commonly use to achieve these skills appears in Figure 8.6. The exercise teaches about cognitive distortions in an interactive manner and introduces coping self-talk. The exercise allows group members to work together collaboratively first on thoughts that are not their own but that may be similar to ones that they have had, and then to identify their own and work on them.

Cognitive coping responses can be practiced in the group in role plays (cognitive rehearsal). During a behavioral rehearsal, a group member doubles as the member who is rehearsing and provides the inner dialogue that member might be having while they perform the desired behavior. A variation on this is to have two members provide an inner dialogue—one who portrays the inner dialogue that includes the automatic thoughts the member might have in the situation being portrayed (which the group member rehearsing might have identified prior to the role play) and one who models coping self-talk. The action alternates between the behavioral rehearsal, the "problematic" inner dialogue, and the coping dialogue. This form of role play not only engages both behavioral and cognitive processes but is also highly interactive and involving for the group members. This doubling technique can be considered a form of psychodrama, which has some empirical support for its use when combined with cognitive-behavioral therapy (CBT) (Avrahami, 2003; Hama-mci, 2006; Treadwell, Kumar, & Wright, 2002).

Extragroup behavioral experiments provide another method for promoting group members' cognitive changes. Behavioral experiments test the validity of beliefs or assumptions. For example, in a panic group, members might simulate a panic attack in a public space to learn that the reactions of bystanders are not catastrophic.

Our discussion of cognitive change methods in CBGW has focused on methods for identifying, challenging, and changing cognitions that lead to negative affect and counter-productive behavior. However, we note here that developments in the "third wave" of CBT emphasize a different approach. For example, in acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), rather than challenging the content of their thoughts, clients work on accepting of their previously unwanted thoughts. Clients are taught to notice rather than avoid the thoughts. Group applications of ACT have been promising (Clarke, Kingston, James, Bolderston, & Remington, 2014).

Exposure

Exposure interventions involve simulated, imagined, or real exposure to a feared situation, sensation, or memory in a setting without danger. With repeated exposure to the feared stimuli without the feared outcome, clients disconfirm their expectations of harm. For some

disorders, clients are experientially also learning that even if their anxiety does not diminish during a trial exposure, they can tolerate the discomfort. Often exposure is graded—that is, a hierarchy is created for milder exposures and then increasingly more challenging exposures. Arranging exposure in a group setting creates some challenges when compared with exposure in individual settings, but groups also provide some benefits for implementation of exposure.

In imaginal exposure, clients vividly imagine the feared situation without avoiding the anxiety that the imagined event triggers. Imaginal exposure is sometimes used when *in vivo* exposure is not safe or possible. In groups for generalized anxiety disorder, for example, members are asked to write a “worry script” that describes in vivid detail their biggest worry (e.g., worrying that they or a loved one will get a serious illness or losing their jobs or failing out of school). In a group setting, members read their scripts out loud to each other. They then listen to or rewrite the worry script outside the group repeatedly and report back to the group on their level of anxiety. Exposure-based treatment for trauma centers on a form of imaginal exposure, which involves describing and repeatedly recalling details of the traumatic event. This type of exposure in a group setting creates the concern that exposure to others’ detailed trauma accounts may be triggering and counterproductive for other group members. Group workers may remain cautious about implementation of trauma exposure in the group setting, but to date evidence does not appear to show exposure methods to be less effective than nonexposure methods in group or less effective than individual CBT methods (Barrera, Mott, Hofstein, & Teng, 2013).

In panic disorder, interoceptive exposure—that is, deliberately inducing feared bodily sensations of panic such as racing heartbeat, dizziness, feeling faint—is key. This is done by simulating these sensations by having the person breathe through a straw, spin in a chair, and run in place. Clients are encouraged to think of the symptoms as uncomfortable but not dangerous. The group is led through exercises to simulate panic symptoms and then to process and discuss their experience in the session together.

In vivo (real-world) exposure to settings that have been avoided because of fear of inducing anxiety can be facilitated through group processes. This can take the form of group brainstorming and planning exposure hierarchies and sharing successes and barriers. Exposure hierarchies are lists of avoided settings or activities in increasing order according to how much anxiety members believe they will elicit. For panic disorder, a member might rank the following in a hierarchy: going to a large mall, taking public transit, driving to feared locations, and traveling a long distance by plane. For social anxiety, a hierarchy might include asking for help over the phone, asking a stranger for directions, speaking to a salesperson at a store, speaking at a meeting, and making small talk with strangers at a social event. Once these hierarchies are constructed, members are instructed to engage in exposures outside the group and then report back to the group about the experience of those exposures.

CBGW can include exposure during group sessions. In a group with members who experience social anxiety, the group can simulate a social occasion in which members have to make small talk or portray an audience for public speaking. In the case of social anxiety, the participation in the group itself, which involves sitting in a room with others, facing their attention and potential judgment and participating in discussion and exercises, is very relevant exposure in itself.

Groups also can arrange for guided *in vivo* exposure. Guided exposure involves exposure of group members to feared situations together with other group members. In a group for panic disorder and agoraphobia, the group may ride together on a bus to a shopping

mall. At the mall, they can form subgroups that carry out various exposures together. These might include riding in an elevator or waiting in long lines. This might also include combining this *in vivo* exposure with interoceptive exposure. For example, members may wear heavy clothing (to trigger sweating), stare at a light (to trigger feelings of unreality), or hyperventilating before entering the store (Bieling et al., 2006).

Relaxation Methods

A variety of relaxation procedures can be applied in CBGW. Relaxation provides a coping skill for dealing with anxiety, stress, pain, or anger. The use of relaxation may be particularly useful when no other external coping behaviors are practical or when cognitive strategies are not sufficient; however, relaxation is often paired with these other interventions. One of the most common relaxation procedures, progressive relaxation, developed by Jacobson (1929), instructs group members to alternately tense and relax various muscle groups. After an initial demonstration by the group worker, the clients teach, monitor, and reinforce each other's efforts in the group for suitable performance and practice.

Some issues can arise in the use of relaxation during group sessions. First, if the group worker leads the relaxation protocol, members are not interacting but are focused on their own internal experience. Postrelaxation processing of what the experience was like can promote sharing and group learning. Some members may be reluctant to close their eyes and experience vulnerability in the group. For some members, relaxation, which requires them to be silent and relatively still, can induce anxiety, and they may report intrusion of anxious thoughts. On the other hand, this experience of shared vulnerability may enhance members' cohesion. We have found that members often report feelings of support, closeness, and caring after participating in a group relaxation session. Relaxation steps cannot be paced as individually as when relaxation is used in individual sessions, and group workers need to remain attentive to how members appear to be responding to the relaxation to modulate the pacing. In order to make active use of the group setting and its potential for mutual aid and support, members can be taught relaxation steps as a group. Then, in pairs, one person relaxes another person in the group, and then the process is reversed. To enhance use outside the group, members may be given audio recordings of relaxation protocols so that they can practice at home. In-home practice can also be aided by smartphone apps that are available.

Numerous other forms of relaxation are included in CBGW. One issue with progressive relaxation is that it calls upon users to devote a substantial amount of time to relaxation (15–20 minutes), which is not practical for use in situations in which stress or anxiety is high in the moment. Applied relaxation (Ost & Breitholtz, 2000) builds upon the base of progressive relaxation, first eliminating the tensing phase for each muscle group (which reduces the time to about 5–7 minutes) and then associating attention to breathing with a cue, such as the word *relax* or *peace* when exhaling. After practice, which entails practicing this multiple times per day outside the group, group members learn to apply this form of breathing in applied situations in which they experience anxiety or stress. In our stress management groups, for example (Tolman & Rose, 1985, 1990), we teach members to pair this type of breathing with coping self-talk. On the inhale, we ask members to note their stressed feelings—“This is one of those times I am getting anxious about getting things done”—and on the exhale, a coping statement—“But I can manage it, so relax.”

A number of additional relaxation procedures have been used, often as part of multicomponent interventions. Meditation, for example, has strong empirical support for its

application in promoting well-being, which has growing empirical support in application to mental health and well-being (Goyal et al., 2014).

BUILDING ON THE PAST AND CONSIDERATIONS FOR THE FUTURE

In this chapter, we sought to update the earlier version authored by Rose (2004). Sheldon Rose, who passed away in 2010, made many of the foundational contributions to the development of CBGW. He conducted one of the most robust programs of research on CBGW in social work (LeCroy & Williams, 2013). He worked on integrating the broader group work literature with the emerging theory and procedures of CBT. His work expanded the clinical literature for work with children, youth, and adults. Many of the lines of research he pioneered continue to be areas of importance looking forward.

For example Rose, Tolman, and Tallant (1985) called attention to the importance of, but lack of research evidence on, the contribution of process to outcome in CBGW. Bieling and colleagues (2006) noted that in a comprehensive search of the literature from 1872 to 2003, only three articles had both the search terms *group process* and *cognitive-behavioral therapy*. They state: “perhaps the most important question to which we have no answer is, ‘Does paying attention to group process matter in CBT?’” Yet to our knowledge, there is no substantive research or tradition of inquiry on this issue in the CBT literature. Work in this area continues to be greatly needed.

The literature of CBGW to date has focused heavily on groups for specific problems or disorders. However, more recently the field has been moving away from manualized procedures for single disorders toward more transdiagnostic approaches. Transdiagnostic approaches focus more on psychological processes underlying the disorders that contribute to the mental health problems. This change holds promise and challenges for CBGW. Transdiagnostic approaches can make group work more flexible by making groups available to individuals across a number of presenting issues. Among other advantages, this can reduce the wait times that might be needed to recruit diagnostically homogenous groups. In addition, clients frequently have co-occurring disorders, and transdiagnostic approaches help to address this issue by addressing the shared core features of disorders and using techniques applicable to a range of problems. Groups using a transdiagnostic CBT protocol have demonstrated noninferiority to groups using diagnosis-specific CBT (Norton & Barrera, 2012) and may be superior when used with clients with comorbid disorders (Norton et al., 2013). Expanding groups to clients with heterogeneous but related disorders raises opportunities and challenges for group process. For example, Söchting (2014) notes that when clients with panic disorder and with social anxiety attend the same group, success is enhanced for members with social anxiety, since members with panic generally have better social skills and are receptive and supportive to those with social anxiety. Clients with social anxiety clients also benefit from a sense of not being alone when they realize the extensive burden that panic plays in the lives of those with panic disorder and their expressions of empathy are well received by those with panic disorder. This example demonstrates the potential advantages of diversity of many types in groups.

Two recent examples exemplify the promise of transdiagnostic formulations of CBT and also focus on the relationship between group process and outcomes in CBGW. Norton and Kazantzis (2015) examined cohesion and therapeutic alliance scores for clients in group transdiagnostic CBT for anxiety. Both cohesion and alliance predicted improvement in anxiety, but cohesion scores were predictive only later in group development. Paulus,

Hayes-Skelton, and Norton (2015) also examined the use of a group transdiagnostic protocol with clients with diverse anxiety disorder diagnoses. Overall, members of ethnic and racial minority groups benefited equally as white group members. However, the most racially and ethnically diverse groups had the poorest outcomes. Specifically, the groups that had single members representing multiple racial/ethnic groups had inferior outcomes, as measured by clinically significant change. The finding that singleton members representing marginalized groups can be at risk for poorer outcomes is not surprising, perhaps, as marginalized status has been viewed as a compositional risk in all types of groups. Although not surprising, the result is disheartening and demonstrates the need for group workers to develop skill not just in compositional heterogeneity. Social work group scholars should further pursue this blending of outcome and process research.

CBGW has found its way into application in settings not generally focused on mental health treatment but familiar to social work. For example, building on the finding that social anxiety disorder was a barrier to employment for women receiving welfare (Tolman et al., 2009), Himle and colleagues (2014) developed a cognitive-behavioral group that could be implemented in a vocational training setting. They conducted a randomized clinical trial with participants who were unemployed, homeless adults with social anxiety disorder. Compared with a treatment-as-usual group, the cognitive-behavioral group significantly reduced social anxiety, generalized anxiety, depression, and functional impairments. Furthermore, vocational service workers, rather than mental health professionals, implemented the group.

CONCLUSION

The intent of this chapter was to describe the cognitive-behavioral group therapy approach, which involves the application of CBT strategies in addition to small-group strategies. This model of treatment is multifaceted, as it is not one single approach but a combination of several different methods. This particular CBGW method recognized the group as a means and context for delivery of the therapy. The group becomes actively involved in the process of conducting therapy. It shares common strategies with other evidence-based models of treatment such as problem solving, social skills training, and cognitive therapy. Groups can be an effective and efficient approach to helping, and practitioners should be specifically trained in the methods described in this chapter.

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PART III

GROUP WORK APPROACHES RELATED TO PURPOSE

INTRODUCTION

Some group approaches have emerged that are related to the major focus of the group. These approaches cut across all fields of practice and are described in this section. The foci we have chosen are self-help and support, psychoeducation, and prevention.

The support and self-help focus seeks to help members who are coping with a broad variety of stressful conditions such as addictions, the stigma of mental illness, or oppression due to sexual orientation. These group members are not likely to be seeking therapy or ways of achieving broad personality change but, instead, to identify and use resources, overcome environmental obstacles, and find acceptance of themselves in a caring and accepting environment. Sometimes these groups have a professional leader, and we refer to these as “support groups.” Some groups are facilitated by peers who are in the “same boat,” and we refer to these as “self-help” groups. Such services have become widely used, and we have devoted the first chapter in this section (Chapter 9) to this topic.

Another purpose is to provide what has come to be called “psychoeducation.” This type of service recognizes that many people can be helped to cope with their situations better and to solve problems if they learn new skills and acquire new information. Many techniques have been developed that social workers can use when they offer this type of group. Thus, another chapter (Chapter 10) is devoted to this type of group.

The third chapter in this section (Chapter 11) discusses groups that are created to *prevent* serious problems. Contemporary strategies have been developed to help practitioners to identify “populations at risk.” Individuals who may encounter such risks can be helped to cope in ways that prevent problems at much less cost to themselves and society before serious problems in functioning arise.

CHAPTER 9

Support and Self-Help Groups

LINDA FARRIS KURTZ

The values of cooperative self-organization and non-bureaucratic mutual helping methods exemplified by hundreds of organizations . . . have penetrated the general culture inescapably and irreversibly. Self-help is seen as a social resource so that people no longer have to suffer in isolation or feel despair that they can find no help in confronting and coping with their problems.

—ALFRED KATZ (1916–2001)

These words were part of Katz's foreword to the seventh edition of *The Self-Help Group Sourcebook* (White & Madara, 2002, p. 5), which listed over 1,100 national and international headquarters of self-help networks in the United States and Canada, many with branches throughout the world—a testimony to the significance of self-help/mutual aid in contemporary society. The *Sourcebook* defines a self-help group as one that provides mutual support, is composed of “peers,” is primarily run by and for its members, and does not charge dues or fees (White & Madara, 2002). The printed sourcebook ended publication and began an electronic version in 2012, a sign of the times.

This chapter is about self-help *and* support groups. Though they are often lumped together, self-help and support groups are *not* one and the same. A key dissimilarity between support and self-help groups involves their leadership. Professional facilitators often lead support groups, although this is not always so. Members may lead them alone, or may share leadership with professionals. Riessman and Carroll (1995) refer to support groups led by professionals as “quasi-self-help forms” (p. 2). Members of the group who share the condition for which the group was formed lead most authentic self-help groups. Many, such as 12-step fellowships, have no official leadership; members rotate the meeting chairperson role. There are, however, exceptions among self-help groups that are not of the 12-step variety. Hybrid groups are self-help in character but have professional sponsors and member leaders (Powell, 1987). There are other characteristics that usually differentiate self-help from support groups.

Typically, support groups are sponsored by larger organizations, such as hospitals or foundations. They are small, and their focus is more on emotional support and reassuring information and less on personal change or advocacy and social action. Admission to membership is typically controlled by the leader or social agency, rather than being open to anyone. Self-help groups are likely to be chapters of large federations of affiliated groups that are national and that espouse a program of either personal or social change (Kurtz, 2015; Powell, 1987). These associations typically welcome anyone who shares the concern of the group. One may refer to both types of group as “mutual help” groups, a term preferred by many.

The purpose of this chapter is to provide a current look at these groups, tips on how to practice with them in mind, and a short summary of research and theory related to self-help and support.

NUMBERS OF SELF-HELP AND SUPPORT GROUPS IN THE UNITED STATES TODAY

In 2006, Goldstrom and colleagues reported on a 2002 national survey of mental health mutual help groups and self-help organizations. They excluded from the survey the following: addiction-only groups; support groups with professional leaders; groups within lodges and clubhouses; and groups for life crises and other conditions that did not limit participation to mental health consumers. The researchers found 7,467 groups that could be defined as “mental health mutual support groups,” “mental health self-help organizations,” or “consumer-operated services” (p. 98). In comparison, there were 4,546 traditional mental health agencies providing professional services in the United States that year. Combined, the three types of mutual support, self-help, consumer-run organizations served 1,581,314 members/meeting attenders in one year.

The largest 12-step fellowship, Alcoholics Anonymous (AA), reported 115,358 groups worldwide (this includes groups in correctional facilities) with 2,138,421 participants in January 2014 (www.aa.org/assets/en_US/smf-53_en.pdf). Looking at other 12-step websites, we find worldwide group numbers for some of the most well-known groups, as follows: Al-Anon Family Groups, 26,500 groups; Gamblers Anonymous [GA], 1,000 groups; Narcotics Anonymous [NA], 61,000 groups; Cocaine Anonymous [CA], 2,000 weekly meetings; Overeaters Anonymous [OA], 6,500 groups; Emotions Anonymous [EA], 1,000 groups. Together these 12-step organizations number more than 200,000 groups.

Foundations such as the Alzheimer’s and Related Disorders Association, the Parkinson’s Foundation, and many others that serve people with chronic diseases sponsor large numbers of support groups throughout the United States and add many thousand to the number of self-help and support groups meeting throughout the country. Several studies have shown that hospitals and health facilities are the most frequent sites for support group services (Lieberman & Snowden, 1994; Mok, 2001; Wituk, Shepherd, Slavich, Warren, & Meissen, 2000).

THE SELF-HELP ETHOS AND PHILOSOPHY

Frank Riessman introduced the concept of the “helper therapy” principle in 1965 (p. 27), but the ancient insight that one helps oneself in the act of helping others had already been rediscovered by the founders of AA 30 years earlier. In AA, the helping process begins when

the participant tells his or her story of drinking and recovery to others; it was this singular act that characterized AA's legendary founding moment between Bill W. and Dr. Bob (Kurtz, 1979). The principle of "helper therapy" is one of the cornerstones of the self-help movement (Riessman, 1965).

Riessman and Carroll (1995) help us understand that "self-help is not synonymous with individual help" (p. 3). Rather, the term is used to emphasize internal helping, whether the helping is internal to a person, a group, or a community. This is in contrast to "external interventions by teachers, experts, clergy, therapists or the state" (p. 3). Self-help interventions do not come from outside the entity; they come from within, and they share the "basic self-help philosophy" (p. 3). The self-help paradigm "views people with problems as potential help givers, as more independent than dependent" (p. 4). The self-help ethos emphasizes empowerment: through a process of identifying the nature of the problem, joining with others, and educating oneself on how to achieve a solution, a person's initial "powerlessness" becomes transformed into being empowered.

PROFESSIONAL INTERVENTIONS WITH SELF-HELP AND SUPPORT GROUPS

Professionals provide leadership and facilitation for support groups, and not for self-help groups. However, professionals can play many other roles with both self-help and support groups (Powell, Hill, Warner, Yeaton, & Silk, 2000; Powell & Kurtz, 2016). These include consulting with, linking to, and supporting groups in their efforts to get started; it may also include working to maintain helping factors in the group's process through consulting with group founders and leaders. All open-ended groups need new members, and newcomers often originate from professional referrals. For example, a recent Al-Anon survey showed that 46% of Al-Anon members were referred to the group by a professional (Al-Anon Family Groups, 2015).

Leading and Facilitating Support Groups

Unlike treatment groups, professionally facilitated support groups are less structured, and members are given more latitude in deciding on the content of meetings. Leaders act as motivators, organizers, and contacts for the group (King, Stewart, King, & Law, 2000). Leadership tasks include "phoning members, organizing and running meetings, finding speakers, maintaining records and documents for the group, dealing with correspondence and phone calls, organizing advocacy activities, planning social and/or fund-raising events, and acting as a contact person" (King et al., 2000, p. 230). It is essential for new support groups to decide what to focus on, how to structure the meetings, and how to divide the meeting time. Some members prefer to spend time discussing their situations, learning coping strategies, and hearing stories similar to their own. Others prefer informational meetings. The role of the facilitator differs depending on what the group decides.

The advantages offered by professional leaders have inspired at least two self-help associations to experiment with professionals as facilitators. One of those was GROW, when that mental health fellowship developed groups in Illinois and became the site of a large research project (Toro et al., 1988). A second instance occurred in Michigan 20 years later when the newly forming Schizophrenics Anonymous (SA) allowed the Mental Health Association to hire professional leaders in order to expand their groups rapidly to meet the need for them

(Salem, Reischl, & Randall, 2008). Both occasions were evaluated by researchers to explore the effect of professional leadership. With GROW, researchers found that in member-led group meetings members felt freer to talk among themselves and initiate topics than in the professionally led sessions. In the case of SA, professionally led groups expanded more quickly but folded earlier than member-led groups. The professionally led group members did not encourage as much experiential knowledge among participants (similar to the finding with GROW) as leaders did in the member-led groups (Salem et al., 2008). Researchers in both cases concluded that whenever possible, indigenous leadership is preferable.

Consulting, Linking, and Supporting

An examination of AA, probably the world's largest and most successful self-help fellowship, shows that, although no professionals are visible in meetings, an underlying professional support system in the alcoholism/drug treatment community sustains it (Kurtz, 1997, 2001). Professionals liberally supported AA during its founding and have continued to do so throughout its 80-year history (Kurtz, 1979; White, 2014). One example of professional dependence on mutual help recovery groups is in physician's health programs (Skipper & DuPont, 2011). These programs provide professional treatment, along with a monitoring system that requires recovering substance-disordered physicians to be involved in some type of group, AA or a similar program, while also undergoing drug testing. Such programs, which exist in all but three states, have remarkable success rates and are considered the model of extended recovery management (White & Kelly, 2011).

Recognition of the significance of support in the aftermath of addiction treatment has led to the emergence of a model known as a recovery-oriented system of care (ROSC) that focuses less on the formal treatment element and more on what goes on before and after treatment; this involves linking between self-help groups and professional treatment centers (White & Kelly, 2011). It depends, in part, on the existence of self-help community groups such as AA, NA, Secular Organizations for Sobriety, Life Ring, Smart Recovery, Women for Sobriety, and others, as well as the treatment entity's willingness to open up to the community (Evans & White, 2013; White & Kurtz, 2006). As one treatment center director stated in an interview with William L. White, "You can drop a treatment center anywhere, but in order to really be successful, we believe that you really have to be connected to the recovering community. They have to know who you are. You have to forge relationships within this community—nothing is more important than that" (Balmer, as cited in White, 2015, p. 12).

Linking between mental health and addiction treatment and self-help groups can be enhanced by the introduction of recovery coaches—individuals who have a history of recovery and who are familiar with the self-help community. These roles are also called by other terms, such as *peer support specialists* in the mental health field, but all have similar qualifications, one being that they are recovering from their own mental health or alcohol misuse condition to the extent that they can offer a road map to others (Kurtz, 2015).

Maintaining Helping Factors

Much theoretical and empirical literature has focused on helping and change-inducing factors in self-help groups, some of which apply equally to support groups (Kurtz, 1997, 2015; Powell, 1987). Lieberman (1979) explored the extent to which change-induction factors were present in self-help groups. He concluded that self-help groups (his sample included one group that today would be seen as a support group) promote feelings of universality

(similarity), support, and acceptance. Furthermore, they have the capacity to generate a sense of belongingness and cohesiveness; they create a refuge for people who feel they are deviant in some way; and they provide a context for social comparison. To this list may be added another, similar helping factor more recently identified by Mandiberg (2012)—that of collective identity formation, which evolves in groups or communities where persons with mental illness find a place where they belong—a place that buffers the effects of stigma and discrimination (Mandiberg & Warner, 2013).

A recent review of research on helping factors and change mechanisms in self-help groups found that Yalom's three factors—cohesiveness, universality, and instillation of hope—figure highly in findings of researchers on this subject (Kurtz, 2015; Yalom, 1995). Cohesiveness, defined as having esprit de corps, is most likely to lead to member willingness to self-disclose and convey warmth and acceptance of one another. Researchers, seeking to understand how AA group climate affects drinking, found that perceptions of group cohesion in AA predicted significant decrease in drinking intensity and increases in abstinence by participants (Rynes, Tonigan, & Rice, 2013).

Universality, realizing that one is not alone, is almost the sine qua non of self-help. In 12-step groups, it's called singleness of purpose. Everyone in the room is linked by one common identity—an inability to control the use of alcohol (substitute other addiction or condition)—and the group's purpose is to carry the message of recovery to those who still suffer. Instillation of hope comes from sharing stories of recovery, which is the reason for telling “what we used to be like, what happened, and what we are like now” (AA World Services, 1976, p. 58). Experiential knowledge, first conceptualized by Borkman (1976) as a feature of self-help, is that kind of knowing which is practical, tied to the here and now, and that, when expressed by someone in the same boat, is unquestioned; recognition between one similarly affected person and another is immediate.

TECHNOLOGY-BASED GROUPS

Technology-based groups, including groups on the Internet and over the telephone, provide useful resources for people who are unable to find local face-to-face groups for their condition or who are not able or willing to travel to the sites where they meet (Galinsky, Schopler, & Abell, 1997; Schopler, Abell, & Galinsky, 1998). Such groups have distinctive individual, group, and environmental features. Individuals can participate anonymously, must be technologically savvy, and can control their self-presentation in ways not possible in face-to-face groups.

Computer Groups

Online support groups are popular with consumers; 28% of a self-selected sample of online users in the United States indicated that their online searches are mostly for online support groups (Ybarra & Eaton, 2005). Most support and self-help mutual aid groups maintain a presence online by way of the Internet and on the World Wide Web. This online presence is of two basic kinds: (1) sites offering *information* and (2) sites making possible *participation* (Kurtz, 2015).

In 2002, 56% of the population used the Internet; in 2013 that number had grown to 84% (Internet World Stats, 2016). In 2002, 1% of online users had visited an online support group, according to the Pew Internet and American Life Project (2002a). According to the

project, 9% of 109 million people (close to 10,000,000) have participated in online support groups at some point in their lives. Ten percent of health seekers in fair or poor health had consulted an online support group the last time they searched for health information (Pew Internet & American Life Project, 2002b).

Computer-based self-help groups overcome several obstacles that confront face-to-face groups. The prospective participant is not dependent on geographical location, nor does he or she need to be concerned about being seen in such a group. One can participate from home, office, a local library, or a community center. For persons who are incapacitated or whose time is limited, computers offer convenience, flexibility, and accessibility (Schopler et al., 1998). One advantage of Web-based groups is their ability to reach special populations. Computer contact reduces barriers of time, distance, and social status, allowing persons with physical disabilities, homebound caregivers, status-conscious professionals, and individuals in remote locations the opportunity to participate actively and on an equal basis with the more advantaged (Cudney & Weinert, 2000; Perron, 2002; Weinert, Cudney, & Winters, 2005). Online AA groups were found by one researcher to offer a necessary supplement for face-to-face meetings by some members and for others an alternate form of participation in the fellowship (Bjerke, 2006–2007).

Self-help on the Internet takes three primary forms (Madara, 1999–2000a). *Listservs* allow members to receive messages delivered to their email addresses and to send messages to all on the subscription list. A second is through the Usenet network that gives access to thousands of newsgroups, also referred to as discussion forums or conferences. “A newsgroup stores messages on a computer in a central location, and can be read and replied to by users” (Madara, 1999–2000a, p. 40). The third is through websites that provide interactive message boards or real-time chat meetings.

Madara (1999–2000b) suggests numerous ways that online groups can be started. Message boards or chat rooms can be placed onto existing websites, agencies can sponsor email discussion on listservs, and newsgroups can be developed on sites such as those of Yahoo.com. For anyone interested in starting a new computer-based support group, Grohol’s guide to online mental health resources gives needed details and instructions (Grohol, 2004).

Telephone Groups

Telephone support groups provide assistance for hard-to-reach users—those who are traditionally deterred from face-to-face groups because of social constraints, geographic isolation, or physical limitations or who are homebound because of their disabilities (Zinoman, Toseland, Smith, & Rizzo, 2005). In addition, some people are unable to use a computer, which keeps them out of online groups. Other reasons for using telephone groups have to do with convenience or desire for anonymity. With chronic illness rising as today’s population ages, telephone support groups can be especially useful in proving feedback systems that allow patients to self-manage more effectively (Cecil, 2014). In the past, telephone groups were expensive, but with today’s conference calling, the expense is minimal (Cecil, 2014; Toseland & Larkin, 2010).

Compared with online groups, telephone groups serve fewer people. Practitioners are urged to keep the size of the group small, from 6 to 12 members, and to choose members carefully (Schopler et al., 1998; Zinoman et al., 2005). In addition, telephone groups must meet simultaneously, making them less flexible than groups online, which can be either real-time chats or more like message boards and email listservs. In contrast to online groups, telephone groups use more familiar technology, which is less costly than having a working

computer. This also makes it possible to subsidize the cost of telephones for low-income populations. Telephone groups are more likely to have professional leaders who can facilitate open communications (Toseland & Larkin, 2010). The lack of visual cues over the telephone makes it important to prompt members to clarify statements to avoid misunderstandings.

CHALLENGES IN SELF-HELP AND SUPPORT GROUPS

In my book on recovery groups (Kurtz, 2015), I summarize 10 types of problems that come up in support groups (many can also apply to self-help groups). The first and most frequent is absence and attrition. This can be due to any number of factors. The time and place may be inconvenient. It may be that the group has been composed of too few members to make it viable if a few are absent. There may be inadequate cohesion in the group, possibly because the members have too little in common. Members may have felt threatened in the group by conflicts among members, episodes in which one member criticizes another, or some other fear of being exposed and embarrassed. There may be an atmosphere of negativity that threatens members, or one or two members may monopolize the meeting.

Psychotherapeutic interventions, such as probing questions, confrontations, and interpretations, are not appropriate activities in either self-help or support groups. In professionally facilitated support groups, the facilitator can establish norms preventing inappropriate advice giving, intrusive questioning, excessive negativity, and other possibly harmful comments. The facilitator keeps in mind that both support and self-help groups normally focus on solutions and coping methods. Large self-help fellowships also establish norms of procedure that are read before each meeting. The focus is on how the program works. For example, a 12-step participant tells his or her story of recovery using the steps. A member of Recovery International gives an example of how he or she applied the Recovery method to a problem of everyday living (Low, 1950). Advice is replaced by stories of “how I did it,” and this is often followed by “but your experience may differ.”

CULTURAL AND GENDER DIVERSITY

Self-help is an international and multicultural phenomenon. This is evidenced in *The Self-Help Group Sourcebook Online* that lists 27 clearinghouses in 11 different countries. Many of the large self-help associations in the United States are international and have groups throughout the world. Azaiza and Ben-Ari (1998) provide one of many illustrations of why such diverse cultures accept the concept of self-help. The authors found that there is a natural fit between the Arab culture and self-help because “Arab professionals are raised within a society which emphasizes the empowering nature of the collective or the community” (p. 427). Arab professionals use self-help as one way to increase the resources available in their community.

That 12-step fellowships and other self-help groups can be molded to fit diverse cultures is undeniable. There are AA, NA, Al-Anon, and other 12-step groups in foreign countries that have different cultures, religions, and customs (Caetano, 1993; Mäkelä, 1996). AA reports groups in 180 countries outside the United States and Canada (AA World Services, 2013), with 61 autonomous general service offices. North American AA (2014) composition is approximately as follows: European American (89%), Hispanic American (3%), African American (4%), Native American (1%), Asian American (1%), other (2%). North American

NA (2015) reports the following composition: European American (74%) African American (11%), Hispanic American (6%), Asian American (3%), indigenous (1%), and multiracial (4%).

Omitting 12-step groups, Snowden and Lieberman (1994) examined minority group representation in California self-help groups and found them to be seriously underrepresented. However, a later study in Kansas found no difference in demographic factors among a broad range of groups in that state (Wituk et al., 2000). Numerous factors beyond ethnicity and race have been identified that could explain racial and ethnic differences in group retention (Heller, Roccoforte, & Cook, 1997; Humphreys & Woods, 1994; Luke, Roberts, & Rappaport, 1994; Mankowski, Humphreys, & Moos, 2001). These factors include language, lack of transportation, "group fit," prior exposure to treatment and to the group, and personal- and group-belief compatibility. Heller and colleagues (1997) found that African American and Hispanic groups participated in family groups when those groups served meals, provided transportation, and had Spanish-speaking members. Several studies have found some evidence that "group fit" (in which a new member resembles the membership of the group) increased attendance by African Americans (Humphreys & Woods, 1994; Luke et al., 1994).

Women are generally seen as more likely to attend self-help and support groups than men; membership statistics of large self-help associations support that generalization. There are, however, important differences in gender makeup depending on the type of problem addressed (Luke et al., 1994; Wituk et al., 2000). Fellowships that serve traditionally male populations, such as AA, CA, and NA, have fewer women members, both because there are fewer women addicts and because the group's male culture may make some women uncomfortable. For example, AA's membership is 65% male (AA World Services, 2013), and NA's membership is 57% male (NA World Services, 2015). Groups with traditionally high female memberships include, for example, Al-Anon Family Groups, Overeaters Anonymous, Recovery International, Parents Anonymous, Candlelighters, Alzheimer's Disease and Related Disorders Association support groups, and Compassionate Friends (Kurtz, 1997).

SELF-HELP AND SUPPORT GROUP RESEARCH

Kyrouz, Humphreys, and Loomis (2002) provided an overview of outcome studies that examined the effectiveness of self-help groups for the 2002 *Self-Help Group Sourcebook* (White & Madara, 2002). Many of the studies they found blurred the boundaries between self-help and support groups, so for this reason, they limited their review of the effectiveness research on self-help groups to studies of groups that are truly self-help in character rather than those groups that are led by professionals. The authors also "focused primarily on studies that compared participants to non-participants and/or gathered information repeatedly over time" (p. 71), thus eliminating single-group cross-sectional surveys that reflected how members felt when they were currently involved in the group.

The summarized investigations were all published between the years of 1977 and 2001. Included were 44 outcome studies representing the following types of groups: addiction-related groups (16 studies); bereavement groups (five studies); cancer groups (two studies); caregiver groups (four studies); chronic-illness groups (five studies); diabetes groups (two studies); groups for elderly persons (one study); mental health groups (eight studies); and weight-loss groups (two studies) (Kyrouz et al. 2002).

The research designs among these 44 studies predominantly (73%) compared outcomes of the same respondents before and after the intervention, compared respondents who followed through with participation with those that did not, or compared participants with matched samples of persons who did not have the problem. For example, a 1999 study (Cook, Heller, & Pickett-Schenk, 1999) compared the outcomes of parents of adult children with mental illness who attended National Alliance for the Mentally Ill (NAMI) meetings with the outcomes of nonattendees.

The other 27% of the studies compared self-help participants with individuals who received an alternate form of intervention. For example, a study of bereaved parents who attended Compassionate Friends (CF) compared parents who attended the self-help group and parents who received psychotherapy (Videka-Sherman & Lieberman, 1985).

Outcome measures for all of these studies varied. For the 16 addiction-related studies, outcome measures included, among others, number of days abstinent, measures of psychological factors such as anxiety and self-esteem, improvements in relationships, size of social network, and costs of follow-up care. Outcomes assessed in the remaining 29 studies included things such as psychological distress, medical symptoms, caregiver burden, increased coping skills and strategies, increased satisfaction with life and with medical care, length of hospital stays, social adjustment, and weight loss. Overall, 39 (89%) of the studies found that self-help participation resulted in positive outcomes; when groups were compared with other interventions, the self-help condition was more effective and more cost efficient. Four of 16 studies, all of substance abuse groups, found that the groups did not produce more favorable outcomes than no help at all or than alternate forms of help. The majority of effectiveness studies of well-defined self-help groups in which methodological rigor was at least partially achieved found most of them to be effective in achieving their goals.

The largest segment of the studies reviewed above was concerned with addiction self-help groups, and those continue to be the most often studied and reported. In recent years, several articles in the lay press have challenged the effectiveness of AA in ways that made it seem virtually useless to recovering people (Glaser, 2015). Members of AA ignore these assaults, but for professionals and academics it would be irresponsible to disregard them. It is true that rigorous, randomized trials evaluating 12-step groups are few and of questionable value due to their small size and narrow exclusion criteria (Humphreys, 2004). The more the researcher controls the evaluation of a self-help group, the less the group is truly "self-help." Nevertheless, hundreds of studies have been done on AA using standardized instruments and sophisticated statistical techniques. These techniques largely make up for the relatively few randomized control group studies owing to the practical and ethical difficulties of such designs (Humphreys, 2004; Kelly & Yeterian, 2008; Powell & Kurtz, 2016). Humphreys concluded in 2004 that, even though many studies examining AA's effectiveness have flaws, those that are less flawed show better outcomes of AA involvement than less rigorous research. In spite of attacks in the lay press, there is no reason to doubt the effectiveness of AA in supporting sobriety for millions of members.

Rather than blaming AA for high dropout rates, serious clinical researchers and practitioners today have examined ways to increase attendance and affiliation after treatment or instead of treatment (Kaskutas, 2009; Kaskutas & Subbaraman, 2011). One successful model is the Physician's Health Program (PHP) that has been implemented over the past three decades in all but three states in the United States with high success rates (Skipper & DuPont, 2011). One aspect of this model is the insistence that participants maintain contact with a mutual help organization. The recovery oriented systems of care (ROSC) model builds on the PHP example (Kelly & White, 2011). Proponents of ROSC depend on

community resources such as AA to supplement professional treatments; they assume that addiction, in some cases, is a long-term, chronic disease marked by relapses and, therefore, in need of long-term community support.

Outcome research is only one type of research on self-help and support. The following discussion of theory will provide some indication of other types of investigations on this subject.

THEORETICAL APPLICATIONS TO SELF-HELP AND SUPPORT GROUPS

Theories that have been applied to understanding self-help and support group functioning and effectiveness include social support (Caplan & Killilea, 1976), cognitive-behavioral (social learning; Kurtz & Powell, 1987; Lee, 1995; Moos, 2011), social control (Moos, 2011); stress and coping (Moos, 2011), reference group (Powell, 1987), social comparison (Davison, Pennebaker, & Dickerson, 2000), social ecology (Maton, 1994), and behavioral choice (Moos, 2011). Moos (2011) applied social control, social learning, stress and coping, and behavioral choice theories to explain how self-help group involvement promotes recovery from substance use disorders.

According to Moos (2011), there are four key ingredients in self-help groups that foster recovery: (1) “the support, goal direction, and structure of a consistent belief system”; (2) “abstinence-oriented norms and values, and the opportunity to identify . . . with role models who follow an abstinent life style”; (3) “an emphasis on bolstering member’s self-efficacy and coping skills”; (4) and “involvement in rewarding activities that do not involve substance use” (p. 53).

Key elements of social control theory involve the provision of “goal direction and structure or monitoring” (p. 48) within and by a family or group (typically, but not necessarily, a 12-step group) which gives support, goal direction, structure, and a consistent belief system that values bonds with family, friends, work, religion . . . or the group, if the previous elements are missing from one’s life” (Moos, 2011).

Social learning theory highlights the availability within the group and recovering community of abstinence-oriented norms and models. Recovering people who have a nondrinking family and friendship support system have better outcomes than those who do not. The group serves as a substitute for a missing nondrinking support system. Cognitive-behavioral theory has been useful in understanding the ways in which some groups help members change thoughts and actions. Social learning principles can be found illustrated in AA and Recovery International, a group for persons with emotional and mental disorders (Kurtz & Powell, 1987).

Stress and coping theory posits that stressful life circumstances diminish an individual’s ability to function, which is due to a lack of adaptive coping skills. Substances are used as a means of coping when individuals lack other skills. In addition, the individual is unable to muster resistance to use and the confidence to avoid high-risk situations. The group bolsters member self-efficacy and alternate coping skills, which research finds is a key factor in sustaining remission and maintaining a stable recovery (Moos, 2011).

Behavioral choice theory posits that the key element in social choice is the alternative rewards provided by activities other than substance use. For example, involvement in education, work, and religious and recreational pursuits reduces likelihood of choosing the rewards if the two are not entwined, that is, substance use is not used along with alternate activities, such as a work environment in which everyone uses alcohol on the job.

Reference group theory is another conceptual tool that can be applied to both support and self-help groups (Powell, 1987). Such groups are highly cohesive, due in part to members having similar issues, for example, alcoholism, overeating, or cancer. Thus their cohesiveness and their availability in a time of acute stress make their power as a reference group quite forceful. As Powell (1987) noted, "the greater the similarity between the individual and the group, the more likely the group will be a comprehensive, durable influence" (p. 75). As a result, participants' self-assessments evolve along with their growing identification with the group norm.

Social comparison theory provides another theoretical base from which to study self-help and support groups. This theory proposes that social behaviors can be predicted as individuals seek to maintain a sense of normalcy and accuracy about their world (Davison, Pennebaker, & Dickerson, 2000). When people are uncertain and under stress, affiliative behaviors increase as people seek others' opinions about what is happening to them. Basing their study on social comparison theory, Davison and colleagues (2000) identified the kinds of illness experiences that prompted patients in four metropolitan areas and in online forums to seek help through support groups. They questioned why professional treatment protocols for some illnesses include mutual support, whereas others do not. These researchers found that, second to alcoholics, cancer patients exhibit the highest tendency to seek and offer support in groups. On the basis of their findings, they concluded that having an illness that is embarrassing, socially stigmatizing, or disfiguring leads people to seek the support of others with similar conditions; people with illnesses such as heart disease do not seek group support to the same extent.

Social ecology theory presents another conceptual framework for understanding mutual help and support groups (Humphreys & Woods, 1994; Luke et al., 1994; Maton, 1994; Moos, Finney, & Maude-Griffin, 1993). Maton (1994) writes, "central to the social ecological paradigm is the assumption that social phenomena occur within and are shaped by a complex, interrelated network of factors that span multiple variable domains and levels of analysis" (p. 137). These variables include, but are not limited to, the importance of niche, group fit, group ideology, individual member characteristics, personal beliefs, existing support systems, social climate of the group, variations due to local conditions, and attitudes of professionals in the local area. For example, the concept of person-environment fit has been used in understanding who stays in and who drops out of groups (Humphreys & Woods, 1994; Luke et al., 1994). Belief-system compatibility between the member and the group is another factor in person-environment fit (Kennedy & Humphreys, 1995; Mankowski, Humphreys, & Moos, 2001).

Pernice-Duca, Markman, and Chateauvert (2013) have combined Bronfenbrenner's social ecology theory and Bandura's social cognitive theory and applied them to the clubhouse model, a psychiatric rehabilitation program that has flourished worldwide in recent years. The clubhouse model emerged from what was originally a self-help program in New York City and that has retained many of its self-help components (Doyle, Lanoil, & Dudek, 2013). Originally, the clubhouse movement evolved in an atheoretical manner, thus the authors' effort to provide theoretical underpinning for it. Pernice-Duca and colleagues' analysis applying ecological theory explains how membership in a clubhouse is more than just a place to go and do work; in a correctly ordered program, the clubhouse is a context of environments that together lead to and shape the member's recovery and sense of identity. Social cognitive theory provides an additional theoretical understanding of how individuals involved in the clubhouse develop collective self-efficacy in a program that goes beyond a focus on individual pathology.

The concept of psychological empowerment has been used to explain mutual help processes (Zimmerman, 1995). Psychological empowerment refers to empowerment at the individual level of analysis, but organizational and community-level empowerment build on the psychological level. Applied in the context of a mutual-help group, this theory directs one to examine whether individual problem solving and coping skill development lead to taking on leadership roles and getting involved in community activities. Maton and Salem (1995) have utilized this approach in an organizational case study of GROW, a mutual-help group for persons with mental illness. These authors found that empowering aspects of the GROW network were provision of a peer-based support system, availability of an opportunity role structure (that allows many individuals to take on meaningful roles), and inculcation of a belief system that inspires members to strive for mental health.

CONCLUSION

This chapter began with a statement on the significance and growth of the self-help/support group movement over the past 20–30 years. Self-help in particular offers the community a free resource that helps members cope with serious conditions: addiction, mental illness, bereavement, cancer. Although professional roles differ in self-help and support groups, their relationships with both forms are vital to the group's existence and well-being. Face-to-face groups may decrease in number and importance as the fast pace of society impels people toward the Internet rather than the more leisurely companionship found in church basements. Professional roles with Internet-based groups will need to evolve, and professional knowledge of self-help must increase if we believe in its value as an essential community resource.

Research on effectiveness and theoretical investigations of group processes and outcomes in self-help and support groups will lead to better appreciation and understanding of the self-help movement. Dissemination of these findings is even more important in gaining public support for them. There may come a day when it will be embarrassing to publish attacks on communities of recovering people who are doing nothing but trying to help each other stay sober, straight, and well—for free. Practitioners, academics, and policy-makers must gain more understanding and awareness of the power of community group resources and of their potential to offer solutions to our rapidly aging, frequently addicted, and stressed-out population. A working knowledge of self-help and support groups will thus become more and more necessary and useful for social work practitioners, professionals, and academics.

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CHAPTER 10

Psychoeducational Groups

JENNIFER ROOT

Many helping professions, including social work, utilize a psychoeducational approach when designing and delivering group interventions with individuals, families, or communities. Offered within a variety of sectors, including health, education, social services, criminal justice, and the military, psychoeducational group work can be conducted with children, adolescents, and adults. The purpose of this chapter is to explore the current state of knowledge and research related to psychoeducational group work with a focus on innovation and contemporary approaches.

This chapter explores social work practice in psychoeducational groups according to the following understandings of group work:

- Learning and personal growth requires the establishment of a safe(r) and responsive environment for group participants and facilitators, held up by a clear understanding of the oppressive and structurally violent spaces group members (including facilitators) may occupy in day-to-day living.
- Information delivery and educational components of psychoeducational group work are strengthened when group processes and emotional responses are purposefully threaded into the work.
- New knowledge is co-created among participants and group leaders. Imagining psychoeducational group work as unidirectional—the *one-way* delivery of information from group facilitator to group participant—is reductive and eliminates the possibility of participants having complementary, parallel, existing, and/or emergent knowledge to contribute to the goals of the group.

The following sections are designed to attune the reader to key facets of psychoeducational group work, including (1) theoretical underpinnings, (2) outcome research, (3) ways of working in psychoeducational groups, (4) programs using psychoeducational approaches, and (5) future directions.

DEFINITION AND TERMINOLOGY

Psychoeducation represents the simultaneous process of educating learners about a particular social problem or issue while attending to the psychological impacts of said issue (i.e., feelings, consequences, possibilities) on group participants. As a group work modality, psychoeducation requires the social work leader to transfer, and ideally co-create, knowledge about a specific issue among group members for the purpose of developing new insight, skills, or strategies. Early definitions of psychoeducation are born from the field of psychology. Guerney, Stollak, and Guerney (1971) suggest:

The practicing psychologist following an educational model is one whose work would derive directly or indirectly from a concern not with “curing” neurosis and not with eliminating symptoms (or complaints) and not with intellectual growth per se but rather with the teaching of personal and interpersonal attitudes and skills which the individual applies to solve present and future psychological problems and to enhance his satisfaction with life. (p. 277)

This definition of psychoeducation continues to be quite relevant to contemporary understandings and applications, given recent explanations regarding the purpose and scope of psychoeducational groups. For example, Corcoran (2009) offers a very accessible explanation of psychoeducational groups:

[They] offer educational material on certain problem areas and skills on how to cope with these problems. Along with education, members’ emotional and psychological reactions to and experiences with the problem, and their reactions to the information presented, are processed. (p. 8).

For the purposes of this chapter, the term *psychoeducational groups* will be used exclusively. On some occasions, psychoeducational groups are conflated with educational groups, or the terms are used interchangeably. This is an unfortunate oversight because psychoeducational groups are distinctly different from educational groups. Although there is some conceptual overlap between these two modalities with respect to group purpose, content, facilitator role, and client expectations, the two approaches are distinctly different. Educational groups do not engage in exploring the psychological impacts and consequences of the social issue being explored. When reviewing traditional and contemporary literatures about psychoeducational groups, it can be helpful to know the various terms practitioners and researchers use (and have used) when designing and delivering psychoeducational groups. The variations in psychoeducational group work described by Brown (2003) include:

- Educational task groups
- Educational guidance groups
- Training/working groups
- Training/relations groups
- Training/social skills groups

Contrary to the exclusive use of the term *psychoeducational groups*, various terms, including *leader*, *facilitator*, *social worker*, and *social work practitioner*, are used to describe the various functions and tasks of a social worker engaged in psychoeducational group practice.

THEORETICAL UNDERPINNINGS

The development and implementation of any therapeutic intervention, including psychoeducational groups, requires congruence between the theoretical foundation and the proposed intervention. Practitioners must carefully consider both (1) the theoretical model they are drawing from when developing and implementing any type of intervention and (2) their personal practice approach and ideological position with respect to the proposed intervention. This becomes especially important when a proposed intervention is guided by a conceptual framework that is inconsistent with or unfamiliar to the group leader's personal practice approach. Social work practitioners are encouraged to think about how a particular theoretical framework will shape a psychoeducational intervention with respect to: (1) the group members, (2) the identified problem/issue, (3) content and methods of delivering information, (4) proposed goals, and (5) the anticipated outcomes. For example, when designing and implementing a psychoeducational group for male perpetrators of intimate partner violence, the information and skill development activities are often aligned with and upheld by principles of feminist theories. In this example, anchoring an intervention in this theoretical framework would require the practitioner to attend to concepts of gender, power, privilege, misogyny, patriarchy, resistance, and so forth. These concepts would directly inform the types of activities the leader would incorporate, the way they might challenge or confront group processes, and the types of goals that are established for the group and individual members.

Although there is no single theory best suited to the effective delivery of psychoeducational groups—in fact, psychoeducational groups are often informed by and structured around stages of group development (e.g., Tuckman's [1965] forming, storming, norming, and performing or Garland, Jones, & Kolodny's [1976] preaffiliation, power and control, intimacy, differentiation, and separation)—psychoeducational group work can (and should be) informed by a particular theoretical framework. Frameworks such as systems theory, cognitive and behavioral theories, social learning theory, ecological theories, and psychodynamic theories can all influence the tone and structure of a psychoeducational group. In addition to feminist theories described above, two additional contemporary theories are explored in detail, given their proclivity of use within the psychoeducational model: narrative/constructivist theories and readiness-to-change theories.

Narrative and Constructivist Theories

Social constructionism proposes that all phenomena are socially constructed. Our beliefs and what we know about the world are the result of social interactions and are thereby social inventions. Any *fact* or *truth* we might hold can be a social construction, including gender, gender identities, sexualities, ethnicities, and so forth. Our understanding of the world, how we experience the world, and how we navigate the world are co-created through our relationship to language, social interaction, and the meanings we give to things.

Compatible with empowerment and emancipatory-based approaches to social work practice, narrative and constructivist foundations have become more prevalent in contemporary approaches to psychoeducational group work. A constructivist practitioner, or a leader who anchors a group intervention in a constructivist framework, assumes group members come to an intervention with experiences and personal narratives born from their unique life circumstances. These experiences can reflect intersecting identities that both privilege and oppress, as well as life experiences that contribute to personal constructions of pain and happiness.

Readiness and Stages-of-Change Frameworks

Readiness-to-change models, the most prolific of which is the transtheoretical model (TTM; Prochaska & Di Clemente, 1982; Prochaska, Johnson, & Lee, 2009), assess individual readiness to form and act on a new behavior, or in some cases depart from an “unhealthy” or undesirable behavior. Generally speaking, the TTM proposes that behavior change can be tracked through five distinct, yet nonlinear stages referred to as (1) precontemplation, (2) contemplation, (3) preparation, (4) action, and (5) maintenance. According to Armitage (2009), the TTM is “arguably the dominant model of health behaviour change, having received unprecedented research attention, yet it has simultaneously attracted exceptional criticism” (p. 195). Reviewing the literature shows that these criticisms are often based on methodologically weak studies demonstrating TTM efficacy (Adams & White, 2005). In fact, findings from two recent systematic reviews of TTM usage in health interventions (Bridle et al., 2005; Riemsma et al., 2003) indicate that TTM-based interventions are no more effective than non-stage-based interventions. Some researchers have posited that the TTM “may be an insufficient basis on which to formulate effective interventions” (Burkitt & Larkin, 2008, p. 429).

In the context of psychoeducational groups, some facilitators do take into account where group members might be in terms of their “readiness to change.” For example, in the context of batterer intervention groups (which are largely based on psychoeducational principles), a group leader would pay attention to how willing the group members are to accept their behaviors as harmful and their ability to work toward meaningful behavior change. A group that is informed by a readiness model would be attuned to various stages of change and its impact on the delivery of information and skill development.

OUTCOME RESEARCH ON PSYCHOEDUCATIONAL GROUP WORK

The following intervention studies demonstrate the impact, and in most cases the effectiveness, of psychoeducational groups. Only studies examining a psychoeducational group intervention versus individual or family interventions were reviewed. Similarly, those designs utilizing multiple intervention components (i.e., psychoeducation in addition to other group intervention approaches) were not included in this review. Studies with and without a control group have been included below as a means for (1) illustrating the breadth of programming and psychoeducational group work being developed and evaluated across various target groups and (2) creating visibility about target areas yet to be studied using experimental designs.

Using these inclusion and exclusion factors, there are a small number of outcome studies that examine the effect of psychoeducational groups on various social problems. This suggests that more studies, especially experimental and quasi-experimental studies, focused on psychoeducational groups (as sole methods of intervention) are needed to more accurately state the efficacy of psychoeducational groups.

Social Anxiety and Children

Vassilopoulos and colleagues (2013) explored the impacts of a psychoeducational group for social anxiety aimed at children ages 9–11. Based on empirically validated risk factors including lack of social competence, interpretation biases, social skills, and depression,

paired sample *t*-tests were conducted using pre- and posttest data ($n = 40$) from three groups of voluntary participants. Findings indicated a significant decrease on scales measuring social anxiety and negative interpretation of ambiguity, as well as a significant increase in children's self-reported likeability, following completion of the group. This suggests that psychoeducational group work can assist young children with identifying and responding to issues of anxiety, fear, and socialization.

Stress

Findings from a meta-analysis by Van Daele, Hermans, Van Audenhove, and Van den Bergh (2012) evaluating the effectiveness of 16 psychoeducational interventions in reducing stress among the general population revealed small but consistently positive effects on stress reduction ($SMD = .27$; 95% confidence interval 0.14–0.40). Findings also suggest that duration of the intervention (shorter v. longer) contributes to the effectiveness of psychoeducational groups in reducing stress. This suggests short-term psychoeducational groups are effective in reducing stress.

Depression, Anxiety, and Psychological Distress

Symptom reduction of depression and anxiety disorders is often approached using psychoeducational techniques, including psychoeducational groups. The meta-analysis by Donker, Griffiths, Cuijpers, and Christensen (2009) investigating the effectiveness of psychoeducation in reducing symptoms of depression, anxiety or psychological distress indicates that psychoeducation reduced symptoms at postintervention ($SMD = 0.20$; 95% confidence interval 0.01–0.40). These findings reveal that psychoeducational interventions for depression and psychological distress can reduce symptoms, but with the important caveat that the quality of psychoeducational intervention is an important factor.

Incarcerated Youth

Roe-Sepowitz, Bedard, Pate, and Hedberg (2014) evaluated a psychoeducational group intervention for adolescent girls involved in the juvenile justice system who have been affected by trauma and childhood abuse. Using *t*-tests, a one-group pretest–posttest design examining the effects of psychoeducational group intervention on decreasing trauma symptoms among incarcerated young women ($n = 320$) revealed significant improvement on 10 Trauma Symptom Inventory subscales. Effect sizes for each of the 10 subscales range from 0.27 to 0.48.

Parenting and Autism

Psychoeducational groups for parents of children with autism spectrum disorder (ASD) have been implemented in various health care and hospital settings given the ever-rising number of children receiving an ASD diagnosis in the past 20 years. Researchers studying a particular brief-intervention psychoeducational model report promising findings with respect to educating and supporting newly diagnosed families (McAleese, Lavery, & Dyer, 2014). These researchers reviewed and evaluated a three-session (9 hours total) psychoeducational group program for parents of children with ASD in Northern Ireland. Over a 12-month period, 83 parents attended the group. While not tested against a control group, pre- and posttest results revealed statistically significant increases in parental understanding of the

(1) social deficits ($F(1, 73) = 193.703; p < .001$), (2) cognitive and behavioral difficulties ($F(1, 73) = 216.831; p < 0.001$), and (3) management and strategies used to support a child with ASD ($F(1, 73) = 174.016; p < 0.001$).

Child Sexual Abuse

Hebert and Tourigny (2010) evaluated the effects of a psychoeducational group intervention for child victims of sexual abuse, ages 6–12 years. Children involved in the psychoeducational intervention offered by a community center ($n = 51$) were contrasted with a sample of children from a comparison group ($n = 39$). Findings suggest that participants in the psychoeducational group reported fewer anxiety and posttraumatic symptoms and relied less on avoidance coping to deal with the sexual abuse than children in the comparison group. The psychoeducational intervention was associated with fewer parent-reported behavior problems.

Exposure to Interpersonal Violence

Domestic violence prevention and intervention are most often approached using a psychoeducational model of treatment. Often referred to as *batterer intervention programs* (BIPs) or *partner assault response* (PAR), these intervention models incorporate key aspects of a psychoeducational group model; they are designed to educate and reorient interpersonal communication and abusive behaviors. Babcock, Green, and Robie (2004) conducted a meta-analysis examining the findings of 22 studies evaluating the efficacy of these programs for men who use violent behavior in their intimate partnerships. Using study outcomes from both controlled quasi-experimental and experimental studies to test the relative impact of psychoeducational therapy (i.e. the Duluth model), cognitive-behavioral therapy (CBT), and other types of treatment on recidivism, findings suggest there were no differences in effect sizes when comparing a psychoeducational model to other interventions.

Brownell and Heiser (2006) conducted an experimental study to evaluate outcomes of a psychoeducational support group for cognitively unimpaired older female victims of abuse by family members. The authors were interested in measuring changes in depression, guilt, and self-esteem among group participants ($n = 9$) compared with a control group ($n = 6$). The findings revealed no change for either the control or the intervention group, suggesting there were no significant differences between the groups before or after receiving the psychoeducational intervention. Although the considerably small size of the sample actually precludes generalizable and/or statistically meaningful conclusions to be drawn, the model of intervention and evaluation instrument developed for the study may be utilized in future studies exploring the impact of psychoeducational groups among mistreated and/or abused elders.

Relationship Quality and Communication Skills

Hawkins, Blanchard, and Baldwin's (2008) meta-analysis examined the efficacy of marriage and relationship education (MRE) on relationship quality and communication skills. The effect sizes for relationship quality for experimental studies ranged from $d = .24$ to $.36$, while the communication skills effect sizes ranged from $d = .36$ to $.54$, suggesting that MRE interventions can be successful in improving the quality of heterosexual marriages. Importantly, the authors suggest that a lack of racial/ethnic and economic diversity in the

samples inhibited their ability to draw reliable conclusions about the effectiveness of MRE for marginalized couples; also, intervention outcomes important to policy makers, such as relationship stability and aggression, have rarely been addressed.

Bipolar Disorder

Although it is not an outcome study, the conclusion of Rouget and Aubry's (2007) systematic review of the psychoeducation literature, evaluating the efficacy of psychoeducation in the treatment of bipolar disorder, suggests that psychoeducation "used alone or as a component of more complex interventions, makes it possible to improve the course of the illness, notably by increasing the patients' and their families' knowledge of the disorder and of treatment options, by decreasing the risk of (hypo)manic or depressive relapse and of hospitalization and by improving treatment compliance" (p. 11). The systematic review included 35 studies across various treatment settings. The treatment setting for 24 of these outcome studies were psychoeducational groups. While group settings represented the dominant mechanism of intervention supporting the conclusions of this literature review, it is important to note that these findings also reflect the use of psychoeducation in individual (four studies), family (six studies), and couples (one study) interventions.

WAYS OF WORKING IN PSYCHOEDUCATIONAL GROUPS

Teaching and Delivering Information

The nature of the educational roots of psychoeducational groups necessarily places social workers in the role of teacher. This role, and by extension the delivery of information, should not be imagined as a one-way relationship between the group leader and the participants. In fact, one of the greatest challenges to a psychoeducational group leader is to overcome the possibility of simply teaching *at* rather than *with* a group of people. Teaching *with* group members inherently draws participants into active engagement in the psychoeducational group, inviting in emotional processing and group dynamics to support and enhance the educational aims. For the emerging or novice group facilitator, the tendency to simply deliver information, without attending to and/or directly engaging with emotions and groups processes, can dilute the individual and group-level impact and outcomes of the group.

Actively engaging group members in the process of psychoeducational group work is supported by various learning theories related to active involvement. Brown (2003) suggests that there are basic principles of learning that must be understood by group leaders in order to deliver effective psychoeducational groups. These basic principles include:

- Selecting optimum methods for delivering information based on participant factors (e.g., age, previous learning, motivation);
- Demonstrating the meaningfulness of material among group members;
- Creating opportunities for group members to integrate new information with existing knowledge and skills; and
- Encouraging retention of new information by doing.

A detailed exploration of group leadership and instructional styles within psychoeducational groups is provided by Brown (2003).

Leadership

Engaging in group work practice requires some familiarity with styles of leadership conducive to facilitating psychoeducational groups. For example, authoritarian, authoritative, transactional, and transformational styles of leadership can be observed in social work practice with groups. Additionally, the composition of leaders can vary in psychoeducational groups based on the aims and content of the group (e.g. solo leadership, coleadership, peer leadership). It's important to note that leadership style and the ways in which individual practitioners engage in group practice, is a subjective endeavor. Differential use of self and self-reflective practices affects the designing, implementing, and evaluating of psychoeducational groups, and each leader's approach is further informed by his or her unique practice values, experiences, and modalities. However, this is not to suggest that there is an absence of best practices or guidelines with respect to leading and delivering psychoeducational groups. Leading a psychoeducational group requires:

- Education and/or training on preparing and delivering psychoeducational groups;
- Knowledge of group processes, including common stages of group development;
- Purposeful and targeted supervision related to group practice;
- Interpersonal practice skills;
- Capacity to self-reflect and challenge personal axes of privilege, power, and oppression;
- Normalizing without essentializing, and
- Connection of group content to anticipated stages of group development.

There is a nuance to navigating a psychoeducational group requiring group leaders and facilitators to hold the tension between delivering educational content and attending to group processes that permit information retention, comprehension, and aptitude. Identifying and maintaining this balance is one of the most important practice skills of a psychoeducational group facilitator. Attending to both the content and the processes in psychoeducational group work requires the group facilitator to hold the tension between these complementary yet often competing processes and to ensure that the integrity of the groups' objectives remain consistent with the structure of a psychoeducational group. The possibility of overattending to affective responses and group dynamics could tip the balance of the group, leaning more toward a therapeutic or counseling type of group, rather than a psychoeducational group. Conversely, failing to acknowledge and meaningfully incorporate emotional responses and group-level dynamics can result in a strictly educational (and unidirectional) group experience.

Facilitation Techniques

Social workers develop their practice approaches based on their individual—and perhaps organizational—practice values, attitudes, and theoretical lenses. It stands to reason that these individual practice approaches will be utilized in the service of delivering psychoeducational groups, regardless of the target group or social issue being addressed in the context of the group setting. For example, social workers delivering psychoeducational groups may incorporate personal practice approaches and techniques consistent with:

- Motivational interviewing
- Trauma-informed approaches

- Response-based approaches
- Strength-based and problem-focused approaches
- Attachment-informed approaches
- Psychodynamic and relational approaches
- Mindfulness approaches
- Indigenous approaches
- Antioppressive, antiracist, anticolonial, antiausterity, and social justice approaches

While certainly not an exhaustive list, this illustrates the various ways that social workers can engage in the practice of psychoeducational group work, regardless of a structured (i.e., manualized) format or a responsive, process-based format. Although some structured psychoeducational groups may require the implementation of a particular technique (e.g., motivational interviewing in an offender treatment program), this should not preclude practitioners from weaving in other engagement strategies consistent with their own practice approaches.

Social Justice Advocacy

Effective communication and interpersonal skills are minimal requirements for a social work practitioner leading a psychoeducational group. There was a time when group work, and those practicing social work in groups, relied heavily on direct practice skills (e.g., warmth, empathy, clarification, validation, reinforcing, confronting) to bring about opportunities for insight and skill development. These skills certainly remain essential to contemporary group work; however, aspects of social justice advocacy should be brought to the fore when designing and leading psychoeducational groups. One could argue the importance of purposefully attending to issues of social justice, marginalization, access, and equity as key practice skills—as important as interpersonal skills—in the delivery of effective psychoeducational groups.

Recognizing how the complex and complicated roles individuals inhabit in their families and communities—caregiver, parent, sister, survivor, patient, employer, and so forth—will come to bear on group composition and dynamics can be an important first step in operationalizing a social justice spirit within the context of a group work. Similarly important is recognizing and honoring the intersectional and interconnected identities of group members; moving beyond dichotomous understandings of gender; considering relationship styles and family compositions beyond heteronormative and monogamous constructions; thinking about diaspora, migration, and their relationship to ethnocultural identity; and imagining the impacts and experiences of institutionally violent and oppressive responses members have likely experienced based on race, class, gender, status, sexual orientation, and other marginalized identities.

The Association for Specialists in Group Work developed a comprehensive set of principles for group workers (see Singh, Merchant, Skudrzyk, & Ingene, 2012), with particular attention paid to the importance of multicultural, social justice, and advocacy competencies. The ASGW calls on group facilitators to incorporate the following aspects of social justice work when delivering therapeutic groups:

- Equity: with focus on a culture-centered approach;
- Access: with focus on understanding identity construction based on differences and deficiency model;

- Participation: with focus on mutuality and authenticity;
- Wellness: with focus on a culturally defined state of being in which mind, body, and spirit are integrated in a way that enables a person to live a fulfilled life;
- Directly address issues of personal privilege, oppression, and oppressive systems that arise in group worker facilitation; and
- Expand the concept of “client” to include systems and communities when examining change.

Structured versus Responsive Groups

Throughout this chapter, structured and responsive (or process-oriented) groups have been referenced with respect to how psychoeducational groups are designed and implemented. Often positioned as dichotomous options for delivering psychoeducational groups, contemporary applications of psychoeducational groups reveals a marrying, or integration, of both structured and responsive elements.

Structured, or manualized, psychoeducational groups have steadily been taken up by social work practitioners and group leaders as an effective (and often evidenced-based) means for practicing social work in groups. A primary criticism of the manualization of group work is its failure to create space for group processes and responsive social work practices. However, recent theorizing and practice within the psychoeducational group field reveals a new trend exploring the integrating structured and responsive approaches. Champe and Rubel (2012) illustrate the utility of a framework for approaching psychoeducational group work based on focal conflict theory (FCT). Their FCT model of group work is designed to attend to both the content and emerging processes within psychoeducational groups.

Similarly, Galinsky, Terzian, and Fraser (2006) explore the complementary nature of practices informed by manualized curricula and those anchored in group processes. By examining the advantages and disadvantages of manualized curricula, the authors highlight the importance of not falling prey to a dichotomous understanding of manualized curricula versus process-oriented groups. They conclude that there is tremendous value to using manualized curricula (ideally evidence-based, but these types of resources remain in their infancy), when flexibility and awareness of the importance of group process is imbedded within group work manuals. Finally, Peled and Perel (2012) illustrate the benefits of attending to both a predetermined structure and arising group processes within a psychoeducational group program for abusive and abused parents.

PROGRAMS AND GROUPS USING PSYCHOEDUCATIONAL PRINCIPLES

Similar to the reviewed outcome studies exploring the impact of psychoeducational groups, there are numerous target groups and social problems being addressed using psychoeducational methods. The following examples explore various applications of a psychoeducational group model. These examples were chosen because they illustrate either (1) a classic approach to delivering psychoeducational groups or (2) new and innovative ways of integrating structural and responsive elements in psychoeducational groups, including hybrid approaches to psychoeducational group work. The selected examples include psychoeducational groups targeting issues of child sexual abuse, parenting and intimate partner violence (IPV), community and school violence, HIV/AIDS, and incarcerated survivors of abuse.

Child Sexual Abuse

Kenny (2009) describes the content and goals of a psychoeducational group, Parents as Teachers of Safety (PaTS), aimed at educating parents and preschool children about childhood sexual abuse (CSA). This primary prevention program is designed to teach parents and their young children about child sexual abuse and its associated harms. The content of PaTS includes general safety rules, communication skills, assertive responses, correct names of genital body parts, knowledge of CSA, appropriate and inappropriate touching, and strategies for responding to disclosures of CSA.

Parents as Teachers of Safety (PaTS) emphasizes improving knowledge and skills related to sexual abuse prevention. Both parents and children attend group simultaneously. Based on the participation of 114 parents and 122 children (ages 3–5) spanning 11 cycles of the 16-session group, the author reported the PaTS group had demonstrated success in achieving its primary goals, including (1) improving communication between parents and children, (2) imparting knowledge of CSA, and (3) guiding parents in how to talk to their children about safety in general, including CSA. These findings, while not an outcome study, provide valuable design insight with respect to the groups' structure. For instance, purposefully staggering the delivery of sensitive group content—material about CSA and personal safety were implemented in later stages of the group—speaks to the importance of developing good group cohesion and trust among members. There are also few examples of dyadic psychoeducational group work. The PaTS group model is an example of how to work with young children and parents using psychoeducation as the primary method of intervention and prevention.

Parenting and IPV

One of the challenges of developing and implementing psychoeducational groups can be the need to balance both the structure and the processes of the group, with one of these factors often driving the focus of the work to the detriment of the other. However, there has been a perceptible, and seemingly purposeful, movement toward integrating various delivery methods of psychoeducational groups. For example, practitioners who might have historically relied on manualized approaches to psychoeducational groups are beginning to capitalize on the strengths of process-based approaches to group work. Peled and Perel (2012) propose an innovative approach to thinking about traditional psychoeducational models of group work—a responsive and structured approach. The authors described their desire to experiment with “preserving the advantages of a structured intervention model, while adequately responding to the group processes and dynamics” (p. 391). They exposed the complexity of navigating structured parenting programs for women abused by their intimate partners and for men who are abusive toward their partners while attending to the nuances and subtleties of group processes. The authors propose a framework for delivering psychoeducational groups in both structured and responsive ways.

Over the course of four years, Peled and Perel (2012) carefully designed, implemented, and refined a parenting-centered group intervention program for abused women and abusive men. The authors put forward guidelines for the development of a structured, process-attentive intervention model (see Peled & Perel, 2012, p. 394 for a review) based on the principles of psychoeducation. The development of this group intervention hinged upon their inclusion of and reliance on dialogues with members of the target population, group members, and facilitators, while maintaining an evolving and flexible design. Most importantly,

the authors identified three desirable attributes of a structured, process-attentive group model: (1) preceding action with understanding (2) modularity, and (3) offering a choice of options. These attributes directly relate to the facilitation principles described by the authors, including working through reactions to the manual; developing “dual attentiveness”; displaying flexibility and confidence; and recognizing all content is connected.

Another example of psychoeducational group applications related to domestic violence, parenting, and child exposure to domestic violence is provided by McWhirter and McWhirter (2010). Project FREE (Family Rejuvenation, Education, and Empowerment) includes parallel psychoeducational group sessions with battered mothers and simultaneous psychoeducational group sessions with their children, followed by a conjoint session with both mothers and children.

Both of these IPV groups utilize a psychoeducational approach that integrates relational processes and group processes (i.e., the dyadic nature of Project FREE and the structured, process-attentive intervention model developed by Peled & Perel, 2012). The innovative elements of each example relate to the inclusion of group members in designing and guiding the trajectory of the group, illustrating the emancipatory potential of these approaches. One might argue that the integrated nature of these groups could help jump-start group processes related to cohesion, trust, and buy-in and reduce feelings of shame, minimization, or denial held by participants who have experienced intimate partner violence or perpetrated family violence.

Community and School Violence

Group-oriented psychological education prevention (GOPEP; McWhirter & McWhirter, 2010) is a manualized, school-based intervention program designed to act as a prevention intervention for “at-risk” children and youth. The program includes four separate school-based initiatives designed to reduce anger, diminish depression, reduce anxiety, and build positive peer and adult relationships through education. One of the four GOPEP programs, SCARE (Student-Centered Aggression Replacement Education), is built around 15 one-hour sessions for a classroom group or as a community-based group program. This program is designed to help students identify and manage feelings of anger, hostility, and aggression.

The SCARE program, in particular, is so innovative because its genesis arose from the writing and ideas of high school students in the Phoenix area. The SCARE program arose from a content analysis of student’s responses to the question: “How can we decrease violence in our schools?” This participatory, and arguably antioppressive and activist-based, approach to group development speaks to why the SCARE program was designated a “model program” by the Office of Juvenile Justice and Delinquency Prevention (see McWhirter & McWhirter, 2010, for a full review). Furthermore, the origins of the SCARE group could be folded into the program delivery—youth developing programs for youth—possibly contributing to group buy-in, cohesion, and willingness to actively participate in the goals of the group.

HIV/AIDS

The Making Positive Changes program (Mason & Vazquez, 2007) uses psychoeducational groups to enhance social support and to provide education on issues affecting families with HIV, particularly HIV-infected parents. Designed for *infected* rather than *affected* parents, the program focuses on key issues of self-care and parenting, with considerable attention

paid to educating parents who are newly diagnosed and providing supportive engagement around developing new parenting skills. This is a classic example of a psychoeducational group model based on the three core objectives of the program: increasing knowledge about the impact of HIV; increasing access to resources and support; and providing opportunities for group members to learn and practice coping skills. In particular, this program focuses on specific parenting skills, including “. . . setting expectations with children; developing rules and family communication; helping teens handle peer pressure; and disclosing a parent’s HIV status . . .” (p. 29).

An interesting component of this group approach relates to the model of cofacilitation: one social work practitioner and one peer facilitator. Unlike other peer facilitation models, the peer leaders do not rotate or switch session-to-session. In this group, peer facilitators remained in their leadership role throughout the duration of the group. In terms of group dynamics, this presents potential opportunities and challenges. Some of the benefits of having a peer facilitator in this context might be similar lived experiences related to a diagnosis and/or prognosis of HIV; mutual understanding; and deprofessionalization of knowledge and methods of delivering new knowledge. Some of the challenges this might present include the perception of not having “authoritative” or “expert” knowledge on the subject; less familiarity with group processes and dynamics; unexamined use of self; and impacts of personal experience on facilitation.

Incarcerated Survivors of Abuse

Women Helping Women Turn around Abuse (ESUBA) is a manualized psychoeducational group program designed for and implemented in various prison systems across the United States (Bedard, Pate, & Roe-Sepowitz, 2003). Developed in the early 1990s, this group is rooted in education, support, and empowerment models with respect to honoring and incorporating past experiences of abuse, harm, and trauma into the psychoeducational format (see Roe-Sepowitz et al., 2014). The objectives of the program explore “how experiences [of abuse] affected the participants in the past, how they affect them currently, how to make changes, and how to deal with the thoughts and feelings that go along with their trauma” (Roe-Sepowitz et al., p. 192).

Unlike some of the other psychoeducational group examples, the ESUBA program was designed and implemented within the context of a social work discipline. Roe-Sepowitz and colleagues (2014) specifically speak to the implications for social work practice and research when implementing this intervention. For example, the authors suggest that more traditional services for incarcerated individuals tend to focus solely on education, rather than treatment or intervention services. The ESUBA program offers social work practitioners working in prison systems an opportunity to implement a structured psychoeducational program attending to both the traditional education components and some of the affective, process-based elements.

FUTURE DIRECTIONS

Psychoeducational groups, in both historical and contemporary contexts, can contribute to positive changes when individuals are faced with adversity. This chapter has reviewed various outcome studies utilizing psychoeducational approaches to intervention, showcased diverse groups and programs designed to deliver education and psychological insight, and,

most importantly, touched on key ways of working in psychoeducational groups. Leaders of these groups must be attuned to and highly competent in interpersonal and group work practiced, but, most importantly, they must be aware of the necessity for a social justice lens across phases of design, implementation, and evaluation.

The promise of psychoeducational approaches lies in innovative methods of delivery. Integrating manualized groups and process-based models of group work offers the best of two worlds—that of evidence-based practices (even the most critical, antioppressive practitioner should be aware of evidence-based approaches as one part of her or his practice approach) and that of the highly relational and process-based methods of client engagement. Similarly, as reviewed in this chapter, reimagining co-facilitation models—reflecting a general shift toward peer support models—proves to be an intriguing possibility with both benefits and challenges. Finally, prioritizing the affective components, rather than the educational component, of these groups could widen the scope of practice for psychoeducational intervention.

The biggest challenge on the horizon for social work practitioners and other helping professionals, who continue to innovate and reimagine the limits of psychoeducation as a modality, will be evaluation. As researcher/practitioners, we must be vigilant in crafting evaluation protocols, research designs, and consistent schedules of program evaluation to demonstrate not only the effectiveness of psychoeducational groups but also to document and measure the innovation itself.

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CHAPTER 11

Social Work with Groups and Drug Abuse Prevention with Youth

Rich History and Untapped Potential

FLAVIO F. MARSIGLIA
ELIZABETH KIEHNE

This chapter provides an overview of the synergy that exists between social work with groups and prevention with youth, and it advances specific pathways to further develop this interface. The harmonious relationship between youth substance abuse prevention and group work is not new. Almost a hundred years ago, the predecessor of the National Association of Social Workers (NASW), the American Association of Social Workers (AASW), was concerned with identifying the fundamentals of social work practice and, specifically, social work with groups (Northen & Kurland, 2001). In her book *The Social Worker in Group Work*, Margaretta Williamson stated that the purpose of social work with groups is to help individuals develop to their fullest capacity and to support optimal relationships between individuals and their environments (Williamson, 1929). This emphasis on person–environment interaction was later reinforced in a presentation at the 1935 National Conference of Social Work in which Wilber Newstetter (1935) noted that group work underscores participants’ development and social adjustment and that “individuals and their social environment are equally important” (p. 297). These remarks highlight the way in which a person-in-environment approach is at the core of social group work.

Following in this long tradition, social work with groups has developed into its own as a field of social work practice and has gained a well-deserved presence across many other disciplines. One of these fields is substance abuse prevention with adolescents. The emphasis placed upon individuals’ social context makes social work with groups particularly well suited for the prevention of adolescent substance use. Developmentally, adolescents’ experimentation with alcohol and other drug use is greatly influenced by their peer groups, family environment, and broader social context (Malekoff, 2014). These influences can support better health or can lead to negative health outcomes. In groups, members can learn or reinforce prosocial behaviors from those who are not experimenting with alcohol and

other drug use or be negatively influenced by those who do. Peer influence and other social experiences during this developmental period make groups an ideal setting for substance use prevention (Malekoff, 2014). In groups, youth are afforded an opportunity to develop communication and democratic skills, to practice offering and receiving support, and to build greater positive connections with peers (Marsiglia, Peña, Nieri, & Nagoshi, 2010). In other words, groups are social laboratories in which youth can learn and rehearse prosocial behaviors.

The development of skills and the strengthening of relationships complement well the content of existing manualized prevention curricula (Marsiglia et al., 2010). The skill development dimension of prevention fits within the group structure as social work with groups shifts the power from the adults to the young group members. Adolescents gain ownership of the group and make it their own by using their own youth language and other communication codes. They are able to share their experiences in a safe space without judging or labeling each other. The group connects the individual members with each other and also links them with their families, schools, neighborhoods, and the larger society. The group is an integral part of the adolescents' ecosystem.

As substance abuse continues to grow among young people in the United States and around the world, groups are increasingly used as the natural home for prevention interventions. In terms of efficacy, some of these prevention efforts range from strong levels of evidence to very little or no evidence. Prevention efforts conducted in groups are not always connected with social work with groups and lack a theoretical approach and evidence of their efficacy. Often, it is difficult to assess the quality and impact of the numerous group-based efforts under way. As a means to advance our discussion in the rest of the chapter, we examine: (1) the extent of the substance abuse problem among youth, (2) the theoretical underpinnings of conducting youth drug abuse prevention through social work with groups, (3) what we mean by prevention, and (4) how we can further integrate youth substance use prevention and social work with groups.

THE EXTENT AND NATURE OF ADOLESCENT SUBSTANCE USE

Inadmissibly high rates of substance use have been found among adolescents of all ethnic groups in the United States (Johnston, O'Malley, Bachman, & Schulenberg, 2007). In fact, among industrialized nations, the United States has one of the highest rates of adolescent drug use (Santrock, 2006). Adolescents in the United States most commonly report using alcohol, tobacco, and marijuana (Johnston, O'Malley, Bachman, & Schulenberg, 2006) and are using substances at a younger age, a phenomenon due in part to rising prodrug attitudes (Donovan, 2007).

Ethnic minorities are at increased risk of substance use compared to their white counterparts. Eighth-grade Latino students have greater alcohol and illicit drug use compared with white non-Hispanic students (Johnston, O'Malley, Bachman, & Schulenberg, 2011). Among eighth-grade Mexican heritage adolescents, specifically, greater than one in five have used marijuana or consumed alcohol heavily in the past year (Delva et al., 2005). Rates of alcohol use vary according to the generation status of Latino adolescents: 6.3% of first-generation (i.e., immigrant) adolescents have used alcohol, compared with 11.6% of second-generation and 7.5% of third-generation Latino youth (Hussey et al., 2007). Higher rates of substance use are also found within the American Indian community, where adolescent drug and alcohol use is prevalent (Beauvais, Jumper-Thurman, & Burnside, 2008). Greater

than 40% of American Indian youth have experimented with alcohol by age 13, compared with 28% of white youth (Rutman, Park, Castor, Taulii, & Forquera, 2008). A similar discrepancy occurs between American Indian and white youth with marijuana (17% v. 9%; Rutman et al., 2008). Furthermore, by 17 years of age, approximately 43% of American Indian youth have used illicit drugs, compared with 16–28% of youth from other racial/ethnic backgrounds (Substance Abuse & Mental Health Services Administration, 2008).

Among all youth, adolescent drug and alcohol use has been linked to a number of negative outcomes. Antisocial behavior, psychopathology, biological brain changes, cognitive issues, motor vehicle crashes, and academic incompetence have all been linked to substance use (Biglan, Brennan, & Foster, 2004; Windle et al., 2008). Furthermore, youth who initiate substance use in early adolescence are at higher risk for prolonged use that extends into adulthood, and they experience more harmful consequences of substance use (Flory, Lynam, Milich, Leukefeld, & Clayton, 2004; Hawkins et al., 1997; Patton et al., 2004). Accordingly, adolescent substance use is a major modern-day public health challenge that warrants systematic, widespread, and timely application of evidence-based prevention programs that are based in theory and that integrate well-researched best practices (Parsai, Voisine, Marsiglia, Kulis, & Nieri, 2008; Pentz, 2003).

THEORETICAL UNDERPINNINGS

Social work with groups draws upon an ecosystems approach to social challenges that takes into consideration the multiple and complex transactions that occur between people and their environments (Northen & Kurland, 2001). In biology, ecology focuses on the study of the relationships between plants and animals; the word derives from the Greek word *oikos*, meaning house (Cook, 1973), or that in which the organism dwells, is influenced by, and influences other organisms and their environment. An ecosystem consists of a community of organisms (i.e., people), as well as the physical elements of the organisms' habitat (i.e., environment; Dies, 1955). The various components of the habitat can nurture or hinder the survival and growth of the individual organisms.

Consistent with an ecological approach, the ecodevelopmental framework is helpful in considering the many protective factors that promote and risk factors that hinder adolescents' well-being. These risk and protective factors can be thought of as operating within a number of nested systems within adolescents' environments (Bronfenbrenner, 1979). The microsystem involves interactions between adolescents and their immediate surroundings, such as school and peers. The next level of youths' environment, the mesosystem, concerns linkages between entities in the microsystem, such as parent–school interaction. Conditions within the exosystem do not directly affect adolescents but do so indirectly by affecting mesosystemic relationships or influences within the microsystem; for example, parents' social support would be an exosystemic influence that indirectly affects adolescents (Coatsworth, Pantin, & Szapocznik, 2002). The macrosystem refers to the broader political, social, and cultural landscape in which youth live, such as cultural values that are individualistic versus communalistic or policies that support the prevention of substance use. The chronosystem captures longitudinal developmental and environmental transitions and changes that youth experience (Bronfenbrenner, 1994; Watling-Neal & Neal, 2013).

Using an ecodevelopmental approach to the promotion of psychosocial functioning, prevention utilizing social work with groups as it medium targets various elements within individuals' environments. At its core, prevention group work is designed to help individuals adapt to conditions within their environment and gain mastery over them in order to

develop to their full potential. Adolescent substance use prevention aims to equip youth with the skills and abilities to deal with the parts of their surroundings that may prevent them from thriving. Protective and risk factors may be present at any level of the ecosystem: individual, family, peer, school, neighborhood, and larger society. The group provides opportunities to rehearse the skills and behaviors, try new things, and gain confidence that they can overcome risks and nurture their assets.

Complementary theoretical grounding to ecological approaches can be drawn from social cognitive theory and social learning theory. According to social cognitive theory, outcome expectations, intentions, and self-efficacy govern the adoption and maintenance of behavior, such as substance use (Bandura, 1986; Van Zundert, Nijhof, & Engels, 2009). Outcome expectations are the perceived advantages and disadvantages of drug or alcohol use; intentions may be operationalized as motivation to use or not use substances; and self-efficacy concerns adolescents' propensity to resist drug and alcohol temptation (Bandura, 1986; Van Zundert et al., 2009). These three domains, outcome expectations, intentions, and self-efficacy, are likely most influenced through intervention in a peer group setting. Furthermore, social learning theory strengthens the theoretical argument for the use of group work in prevention programs. Social learning theory suggests that behavior is learned through social interaction and that people form their attitudes toward behavior through association with others (Akers, 2001; Bandura, 1977; Pratt et al., 2010). It asserts that assumptions regarding one's environment are made as a result of perceptions of others' attitudes and behaviors. In the context of adolescent substance use, overestimating peer substance use may encourage individuals to engage in substance use themselves (Bandura, 1977; D'Amico et al., 2005). The impact of social work with groups in prevention is further validated due to its generalizability. Behaviors learned in a group context are also thought to enhance generalizability; group members can more easily apply the life skills learned in a variety of other contexts (Botvin & Griffin, 2004; Malekoff, 2014; Wodarski & Wodarski, 1995).

Group work helps youth to develop clear life goals and to identify the factors that are helping or not helping them reach their goals. The dress rehearsal takes place in group; the real play takes place within the concentric circles that surround the group. The life script written in group becomes a source of commitment that youth make with each other for much longer than the life of the group.

SUBSTANCE USE PREVENTION IN ADOLESCENCE

As a developmental period of heightened physical, social, and psychological growth, adolescence is an ideal time to conduct substance use prevention efforts. Development of the prefrontal cortex and cerebellum during adolescence increases the ability to reason, be reflective, control impulse, and use judgment (Casey, Jones, & Somerville, 2011). Concurrently, adolescent neurodevelopment occurs in brain regions associated with motivation, impulsivity, and addiction. Adolescent impulsivity, sensation, and novelty seeking are associated in part by the maturational changes occurring in frontal cortical and subcortical monoaminergic systems (Chambers, Taylor, & Potenza, 2003). These developmental processes may help promote adaptation to adult roles, but they may also confer greater vulnerability on the addictive actions of drugs. During this phase of development, young people learn quickly, experiences make strong impressions on them, and they are very porous to outside influence, both positive and negative (Malekoff, 2014). Thus adolescence is a period of rich prosocial learning, such as substance use prevention, and also of increased vulnerability to

antisocial influence, such as substance-using peers. There is general consensus that the ideal time to implement substance use prevention intervention with youth is during preadolescence and early adolescence (Steiker, 2016).

Universal, Indicated, and Selective Prevention Interventions

Prevention interventions are divided into three categories based on their target group: (1) universal, (2) selective, and (3) indicative (Neil & Christensen, 2009). Universal interventions are the most common and target all youth regardless of their risk status; they are a form of primary prevention. Universal prevention programs target a population of youth, such as whole classrooms or schools, and have limited or no selection criteria (Rapee et al., 2006). The implementers of these programs tend to be community agency personnel, schoolteachers, and other adults without extensive training in the area of substance use but ideally trained on the manualized intervention they are implementing. Conversely, adolescents are selected or self-select into an indicated prevention program on the basis of heightened risk or early experimentation with drugs or alcohol (Marsiglia et al., 2010). Trained mental health professionals often deliver indicated programs (Rapee et al., 2006). Finally, selective interventions target adolescents identified as at risk for substance use, due to individual or environmental characteristics. The line between prevention and treatment within this age group is not well defined. Many prevention interventions could also be considered early treatment interventions, as they deal with adolescents who were already experimenting at baseline assessment.

Universal prevention programs have the potential to reduce stigma but are also more costly, may have less effect at the individual level, and are more impersonal (Offord, Chmura Kraemer, Kazdin, Jensen, & Harrington, 1998). On the other hand, indicated programs are more personal and have the potential for greater impact at the individual level; they have a more limited reach, however, and may stigmatize members (Offord et al., 1998). Selective interventions fall within the end of the prevention spectrum and have a stronger overlap with treatment. Group work is appropriate in any of the three levels of prevention. Social work with groups, however, tends to be more common in indicated and selective interventions, whereas universal interventions tend to be more commonly implemented in classrooms by teachers and not by social workers.

Social Work with Groups

Social work with groups, when applied to prevention interventions, conventionally forms groups of 2 to 20 members to act as a social system (Northen & Kurland, 2001). The whole of the group is greater than the sum of its parts; the system comprises the individual members plus the functioning and interpersonal dynamics of the individual members and group process (Davidson, 1983). Although prevention-oriented groups can develop in divergent ways, depending in part upon the type of group, generally group development follows the traditional three main stages (Toseland, Jones, & Gellis, 2004). The first stage involves the establishment of the group identity and formation. At this stage, interactions are tentative, as rules and norms develop. As a group culture begins to emerge, group members interact more boldly, and conflict may arise. Once the group is born, the intermediate stage starts, which is characterized by productivity and goal achievement. Lastly, the ending stage focuses on task completion, group evaluation, and closing ceremonies (Toseland et al., 2004).

In prevention-oriented social work with groups, participants are not just spectators passively receiving information, as in the traditional classroom environment (Macedo & Freire,

2003; Marsiglia et al., 2010). The role of the participant in group work is active, and the role of the facilitator is to guide and engage, not to lecture. Participants are encouraged to become intimately involved in the group processes and activities, such as evaluating options, brainstorming, role playing, rehearsing, reflecting, and listening actively (Gitterman, 2004; Hart, 1990). Facilitators create a sense of safety within the group to support active participant engagement, through which members can realize their power and potential; they must also encourage group ownership through transformative discourse that ensures that all group voices are heard (Freire, 1998).

Given the great influence of peers and the importance of social experiences during adolescence, the use of group work is well suited for adolescent substance use prevention efforts (Malekoff, 2014). Adolescent substance use prevention programs are designed to minimize risk factors and enhance protective factors associated with the use of alcohol and other drugs. When delivered through a group format, adolescent substance use prevention can target a key protective factor, bonding and social support (Hawkins, Catalano, & Associates, 1992). Thus, in addition to beneficial antidrug content, group work helps build a protective network of support for youth, which may be particularly important for minority youth.

Cultural Responsivity

Consideration of and attention to culture and diversity is essential to social work practice (National Association of Social Workers, 2008) and, specifically, social group work practice (Malekoff, 2014). It can also be argued that group work is vital to culturally responsive practice for racial/ethnic groups that are more collectivistic than individualistic (Marsiglia, Cross, & Mitchell-Enos, 1999). Group work that fosters peer interaction and collaboration may be especially important for these groups. For example, the American Indian traditional value of group centeredness may make group work a particularly appropriate mode of prevention intervention. Furthermore, the mutual aid group work approach may be particularly helpful for immigrant youth as they face issues associated with dislocation and transitional stress (Steinberg, 2002). Mutual aid components allow peers with similar experiences to connect, adding to their social network of supports (Marsiglia, 2002). Additionally, shared values surface, as well as contradictions in expectations or cultural norms between home, peer groups, and school (Marsiglia et al., 2010). These contradictions are dealt with in group, learning from others who may share the same stressors and who are effectively coping with them.

Benefits of Group Work in Prevention

A group learning environment is advantageous for adolescents for a multitude of reasons. First, substance use itself often occurs in a group setting; therefore, teaching resistance to alcohol and other drugs in a parallel setting makes sense conceptually (Malekoff, 2014; Wodarski & Wodarski, 1995). It is more probable that skills, knowledge, and attitudes gained in a group setting will be utilized in similar real-life group environments. Furthermore, group work allows for various types of learning experiences to take place (Wodarski & Wodarski, 1995). It allows for experiential, interactional, and vicarious learning that promotes youth teaching and learning from one another. It also affords youth the opportunity to practice new skills together and provide support and feedback to one another (Gitterman, 2004; Nash & Snyder, 2004). Particularly in indicated prevention programs, group work can assume a mutual aid component whereby members become helpers in providing information

and support (Malekoff, 2014). This can fortify interpersonal skills, advance identity formation, and build decision-making skills (Hair, Jager, & Garrett, 2002; Marsiglia et al., 2010). It can also build critical-thinking skills, a democratic orientation, relationship skills, and greater connection among peers (Marsiglia et al., 2010). Furthermore, strengthening these peer bonds, particularly among prosocial non-drug-using peers, can result in stronger anti-drug attitudes (Bogenschneider, 1996; Hawkins et al., 1992). Group work has the potential to be a part of adolescents' protective networks of supports to avoid or overcome the use of alcohol and other drugs (Malekoff, 2014; Selekman, 2005). Accordingly, group work is a preferred method of delivery for substance use prevention for adolescents.

ADOLESCENT SUBSTANCE USE PREVENTION PROGRAMS

Adolescent substance use prevention best practices include promoting an interactive learning environment that involves teaching methods such as peer discussion (Pentz, 2003). For this reason, group work has long been the normative modality in adolescent substance use prevention programs (e.g., Hansen, Johnson, Flay, Graham, & Sobel, 1988). A number of classroom and small-group-based substance use prevention curricula have been developed for use with adolescents. Several have demonstrated a statistically significant reduction in substance use compared with control groups and thus are recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as evidence-based. Table 11.1 provides basic information about 14 SAMHSA-recognized evidence-based adolescent substance use prevention programs and lists the targeted age group, level of prevention, and format.

As demonstrated in Table 11.1, the majority of evidence-based adolescent substance use prevention programs have been designed to be classroom-based. With the exception of two programs, the large-group setting is primarily the medium through which substance use prevention is delivered, particularly at the universal level. This is due to a number of factors, which include feasibility, access, and cost-effectiveness. Educators who have already developed their ability to teach youth effectively can implement manualized universal programs, and the classroom is an efficient captive audience for such prevention messages. The relative absence of manualized and evidence-based adolescent substance use prevention utilizing a small-group format represents a gap in prevention programming. While large-group prevention efforts (i.e., classroom-based) are beneficial and effective, prevention with small groups is an untapped resource at all levels of adolescent substance use prevention. Therefore, large-group prevention interventions should continue to be developed; however, a call for future research that develops and systematically investigates the benefits of small-group work in adolescent substance use prevention is warranted. A case study will further illustrate some of the existing tensions and opportunities. The two interrelated group-based prevention programs are *keepin' it REAL*, a classroom-based program, and *REAL Groups*, a small-group-based program.

CASE STUDIES

keepin' it REAL (kiR) is primarily a universal group-based prevention curriculum, and *REAL Groups* is a selective and indicated small-group prevention curriculum. A body of evidence supports the effectiveness of both kiR (Hecht et al., 2003; Kulis et al., 2005) and *REAL Groups* (Marsiglia et al., 2010) in reducing and delaying adolescent substance use. Unlike many group-based prevention programs, culture is a defining feature of both kiR

TABLE 11.1. Evidence-Based Adolescent Substance Use Prevention Programs

Program	Age group	Level of prevention	Format
All Stars	11–14 years	Universal/selective	Classroom-based
Alcohol Literacy Challenge	Elementary school through college	Universal	Classroom-based
LifeSkills Training	Elementary through high school	Universal	Classroom-based
Class Action	11th–12th grade	Universal	Classroom-based
keepin' it REAL	12–14 years	Universal/selective	Classroom-based
Media Ready	6th–8th grade	Universal	Classroom-based
Prevention through Alternative Learning Styles	Middle school	Universal/selective	Classroom-based
Project ALERT	Middle school	Universal/selective	Classroom-based
Project SUCCESS	13–17 years	Universal/selective/indicated	Classroom-based
Project Towards No Drug Abuse	High school	Universal/selective/indicated	Classroom-based
Stay on Track	6th–8th grade	Universal	Classroom-based
Residential Student Assistance Program	12–18 years	Selective/indicated	Small group
The PreVenture Program: Personality-Targeted Interventions for Adolescent Substance Misuse	13–15 years	Selective	Small group

and REAL Groups and is integrated into the interventions as an asset group members bring with them in reducing or delaying adolescent alcohol and other drug use (Gosin, Marsiglia, & Hecht, 2003).

keepin' it REAL

kiR is a universal classroom-based adolescent substance use prevention program in which culture is a central element (Hecht et al., 2003; Marsiglia, Kulis, Wagstaff, Dran, & Elek, 2005). Culturally relevant activities foster discussion of the importance of cultural values and develop cultural and personal strengths (Marsiglia & Hecht, 2005). In addition to being culturally relevant, kiR is designed to be developmentally, socially, and academically relevant (Harthun, Dustman, Reeves, Marsiglia, & Hecht, 2009). The program places heavy emphasis on negotiating peer interactions, making it well suited for implementation with groups of adolescents (Gosin et al., 2003).

Recognized as an evidence-based model program by SAMHSA, kiR was designed to help youth develop the social skills necessary to successfully resist drug use (Gosin et al.,

2003; Selekman, 2005). The aims of the program are to (1) increase skills that aid in drug resistance; (2) encourage anti-substance use attitudes and norms; and (3) improve decision making and communication skills for the purpose of resistance (Marsiglia & Hecht, 2005). The curriculum consists of ten 40-minute lessons implemented by trained teachers in the classroom. Through a series of videos that were scripted, acted out, and filmed by peers, youth increase their capacity to resist drug offers using the *Refuse, Explain, Avoid, and Leave (REAL)* drug resistance strategies (Hecht et al., 2003; Marsiglia et al., 2005).

Cultural Specificity

The cultural appropriateness of prevention programs is considered a critical element of effectiveness (Pentz, 2003). The integration of cultural traditions, beliefs, and norms into prevention messages is integral to substance use reduction for racial/ethnic minority youth (Hecht et al., 2003). Accordingly, three cultural adaptations of the kiR curriculum have been created (Harthun, Drapeau, Dustman, & Marsiglia, 2002). Embedded and affirmed in each version of the curriculum are the most salient cultural norms and values pertinent to successful substance use resistance for that cultural group (Collier, Ribeau, & Hecht, 1986; Hecht, Ribeau, & Alberts, 1989; Hecht, Ribeau, & Sedano, 1990). The infusion of cultural norms and values offers a more nuanced approach to the use of the REAL strategies.

The multicultural version of the manual is commercially available (Marsiglia & Hecht, 2005), and it integrates Latino cultural norms with European American and African American cultural norms (Harthun et al., 2002). By having these cultural values and norms embedded in the kiR curriculum, youth can better identify with the resistance strategies, making them more likely to utilize them in real instances of drug offers and encounters (Harthun et al., 2002; Hecht et al., 2003). As an example, lesson 4 covers the drug resistance strategy “refuse.” Students are encouraged to discuss comfortable ways in which they say no and set firm boundaries. Options offered or modeled include, “No, no thank you,” “I said no,” “No, get out of here!” and “That’s stupid!” Participants are instructed to be clear but not to attack or embarrass others (i.e., reflect *simpatía*). Accordingly, a refusal option presented to participants is, “I really like hanging out with you, but I’m not into smoking.” This is modeled in the video by the adolescent thanking his peers and then excusing himself while acknowledging that the reason is “all that smoking” as he walks away (Harthun et al., 2002).

Classroom teachers receive intense training before they start facilitating the intervention. Classroom size, on average, is 24 students. In order to allow for group process and participation, most of the classroom-based exercises and discussions take place in smaller groups of no more than 4–5 students. Role plays, games, and art projects are used to encourage ongoing participation and engagement. Homework is used as a means of connecting the child’s family and home environment to the work being done in the classroom (Gosin et al., 2003). It is estimated that approximately 150,000 middle school students around the United States and in other countries have participated in kiR. The manual is being used in 48 states and at least six other countries. As the well-known and broadly disseminated D.A.R.E. program is being revised, *keepin’ it REAL* is the new D.A.R.E. (D.A.R.E., 2015).

REAL Groups

As a complement to the universal kiR curriculum, an indicated prevention program designed for Mexican and Mexican American adolescents was developed, called REAL Groups

(Marsiglia et al., 2010). REAL Groups are culturally grounded for Mexican/Mexican American youth, specifically. The curriculum is rooted in the norms and values of youths' culture of origin, as culture of origin involvement is associated with antidrug norms and protective against substance use (Marsiglia & Kulis, 2009). REAL groups are small psychosocial groups designed for approximately 10 students (Marsiglia, Ayers, Gance-Cleveland, Mettler, & Booth, 2012). A REAL group is intended to provide extra prevention intervention to youth at higher risk for substance use. Participants receive both the teacher-taught classroom-based kiR program and the eight-week psychosocial group. The groups are built on the mutual aid approach, which encourages youth to connect with peers who may be going through similar processes and to strengthen their interpersonal relationship skills (Marsiglia et al., 2012). This may be particularly beneficial for youth from ethnic minority groups who can connect on shared values and conflicts they experience between their culture of origin and the mainstream culture (Marsiglia et al., 2010). Culture is explicitly addressed in REAL Groups, such as discussion of antidrug norms that are culturally supported. Additionally, youth are prompted to rehearse the REAL drug and alcohol resistance strategies, tying in various aspects of their culture (Marsiglia et al., 2012).

REAL groups tend to be facilitated by school social workers, and their role is to encourage active participation from group members (Marsiglia et al., 2010). Facilitators engage participants in active listening, evaluating options, brainstorming, planning, role playing, rehearsing, and reflecting on lived experiences and choices (Gitterman, 2004; Hart, 1990). This is reflective of the Freirean (1998) model of learning, which emphasizes empowerment and representation of group members' voices. The ultimate goal of the facilitator is group ownership by the members. Accordingly, as the weeks proceed, the facilitator should find her- or himself speaking progressively less.

The REAL Groups' manual is not yet commercially available, but it has been patented by Arizona State University. Social workers and group members participating in the program have expressed high levels of satisfaction with the intervention. Pre-posttest comparisons have shown significant changes in the desired direction (Marsiglia et al., 2010). More research is needed with large samples and in different geographic locations before the existing findings can be generalized.

The two examples illustrate the opportunities and the tension that social work with groups and substance use prevention face while serving the needs of preadolescents and adolescents. Because most universal prevention efforts take place in the school context, the classroom as a group approach cannot be ignored. Classrooms are groups, but due to their size and structure, they may not be conducive to group process. As Paolo Freire (1970) wrote a long time ago, students looking at the teacher and giving their backs to each other feeds into the banking approach. The banking approach concept is based on the assumption that the teacher is the only one who has knowledge; the students come to class with empty heads. The metaphor of the banking transaction illustrates this relationship by using the funds as knowledge and the bank accounts as the students. According to Freire, a further assumption is that the students do not possess any knowledge to share with each other and that that is the reason why most classrooms are designed in rows facing the front. In group work, we use the circle instead. The circle conveys the opposite message, that is, we all learn from each other in group, and all opinions are equally valid. The facilitator has a unique role to play, but she or he is one more in the group or the circle. We were able to compare the communication flow between the two interventions. During the first sessions of keepin'it REAL we needed to remind the teachers about group process, but soon after they integrated the concept and made it happen.

In the REAL Groups, group process emerged naturally and was constant. There is a need to continue to implement more programs like these as a means to develop much-needed knowledge about group work and its intersection with prevention. Our recommendation is to strengthen the multidisciplinary collaboration within the schools and embrace the prevention continuum. Figure 11.1 graphically shows the proposed model. On the universal (left) end of the spectrum, we have the classroom teacher taking the lead and conceptualize the classroom as a group. In the middle (selective), the social worker and the teacher partner to provide social work with groups, and at the right end (indicated) of the spectrum the social worker leads the small groups addressing the more targeted needs of students.

As Figure 11.1 illustrates, the three levels of prevention are within a continuum based on the needs of the students, but the three levels of intervention are not mutually exclusive. Students may start at level 1 (universal) in the classroom, and if a student discusses alcohol or other drug abuse at home, she or he may be referred by the teacher to the school social worker. The student at that point may join an ongoing small group addressing selective prevention. As the group process evolves, the social worker may invite the student to join a different group (indicated), formed by students already experimenting with alcohol and other drugs.

SUMMARY, CONCLUSION, AND IMPLICATIONS

The purpose of this chapter was to highlight the opportunities and challenges associated with social work with groups and school-based prevention. The review of the literature, the proposed theoretical foundations, and the perspectives from the field demonstrate that the potential and opportunities are vast. The synergy between group work and prevention is strong, but there is room for further integration. There is a natural tension that comes from the way student learning and schools are structured. Manualized universal prevention interventions such as keepin’it REAL help overcome some of those obstacles.

Teacher training is essential, but also the engagement of teachers needs to be rewarded and encouraged in tangible ways. Teachers can contribute their expertise at the same time that they acquire additional skills in group facilitation and prevention strategies. Monetary

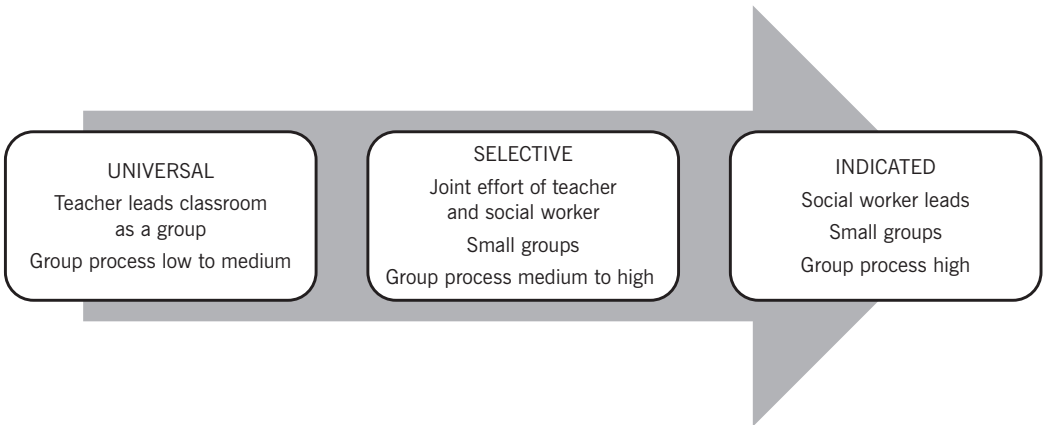


FIGURE 11.1. Social work with groups within the prevention continuum.

remuneration, continuing education credits, or other creative incentives will keep them motivated and engaged.

Social workers seem to be better suited for the selective and indicated prevention interventions. Their training in group work and in prevention makes social workers ideal small-group facilitators in the school setting. Well-developed and easy-to-use referral protocols are essential in order to make the groups accessible to the students that need them the most. In this case, manualized interventions are also recommended, but structured training sessions may be less necessary. Providing a repertoire of prevention interventions ranging from (1) universal and classroom-based to (2) selected and social-worker-led to (3) indicated and social-worker-led interventions will address the spectrum of prevention needs students present.

In conclusion, not all groups and not all prevention interventions are equal. Developing a clear road map at the school or agency setting about the purpose of each intervention and its desired outcomes will strengthen the synergy between social work with groups and prevention. This integrated approach will require close coordination between the teachers and the social worker, and this can only happen with administrators' support.

More research is needed to assess the impact of each evidence-based intervention and the added impact of multiple interventions operating at multiple levels of need. Adding other ecosystems will also increase the impact of these combined efforts. The family and the neighborhood seem to be a clear next ecosystemic level that needs exploration and integration. In the meantime, let's redesign some classrooms and increase the social work presence in the schools. Our children and society at large will greatly benefit from it.

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PART IV

GROUP WORK APPROACHES RELATED TO SETTING

INTRODUCTION

As we stated in the introduction to this book, groups are offered in all of the kinds of agencies in which social workers are employed to help people who have personal difficulties. Although some ways of working may be used with all groups, other ways are idiosyncratic to the kinds of problems addressed. Some models of practice may also be more effective with one type of problem than another. We have chosen for this section a set of fields of practice that we believe represents a broad array of types of practice and includes those that are most often written about and included in group work curricula.

For this section, therefore, we have recruited writers who are experts in the use of group methods and models most appropriate for use with those populations. Some of these populations are defined by age of members and some by types of problems. In addition, some categories, such as “involuntary groups,” deal with how to work with people with several types of problems (Chapter 14). We have separate chapters in addition on inmates of prisons (Chapter 23) and on family violence (Chapter 20), as we believe these are important issues that demand the extensive coverage we have devoted to them.

Since the first edition of this book, it has become apparent to us that some types of groups were not included in that edition. We previously combined groups for people with mental health issues and physical health issues into one chapter but have concluded this does not do justice to the topic, so we have commissioned two chapters (Chapters 12 and 13). In addition, we have added chapters on groups for people involved in domestic violence (Chapter 20), groups for people who are recent immigrants (Chapter 21), groups for ex-offenders (Chapter 23), and groups to promote intergroup relations (Chapter 22).

In addition, we have included, as we did in the first edition, two chapters that focus on service to children. Chapter 15 presents the ways that a highly creative practitioner

and writer works with children who come to the group for help with such problems as recovering from trauma, poor functioning in school, or lack of skills in developing relationships with peers. Chapter 16 presents the creation of groups in the child welfare field to help children with such problems as child abuse or the breakup of their families.

Our chapter on groups in substance abuse programs provides a comprehensive review of the problem of adolescent substance abuse and the role of groups in addressing them. The authors discuss three theoretical models that inform evidence-based approaches to youth substance abuse prevention and describe their use in the field. It provides an excellent perspective on how theory and research can be translated into effective group-based substance abuse services.

Many programs that serve older adults offer groups to meet many kinds of needs, and Chapter 18 presents this array of services. We also have presented an updated chapter on the use of groups to help people who are involved in intergroup conflicts due to their ethnicity, national origins, race, religion, social class, or other attributes that can separate people. These kinds of conflicts occur throughout the world today and lead to vast amounts of human suffering. It is not an accident that the author of this chapter has been involved in helping Palestinian and Jewish Israeli youth to deal with conflict in nonviolent ways. Chapter 19 also deals with intergroup conflicts and presents other models for promoting a peaceful world.

CHAPTER 12

Group Work in Health Care Settings

BRIAN L. KELLY

Since the early 20th century social workers have played an important role in the coordination and provision of services in various health care settings, including primary care facilities, hospitals, specialty clinics, schools, home health care settings, hospice care settings, continuing care settings, private physician groups, and research settings. Although, historically, social casework and social diagnosis have been the predominant model of social work practice in health care coordination and provision, group work has played an important role in health promotion and the assessment and treatment of diseases and disorders within health care settings.

Social workers and group workers in health care settings incorporate a biopsychosocial perspective in their practice, which seeks to recognize the whole person as she or he exists within her or his environment. Although this holistic approach allows the consideration of clients' strengths, the majority of research and literature on group work in health care settings is grounded in a problems-based approach, in which the primary focus of intervention is the client's disease and its related problems. This critique is not to say that group work interventions for illness prevention, treatment, care, and support are not needed. Rather, it suggests that there is room within the literature on group work in health care settings to explore existing strengths-based models of group work practice and explore their utilization, particularly with vulnerable and oppressed populations.

This chapter explores the use of group work in health care settings. It begins with a brief review of group typologies and dynamics, with particular attention to their qualities, relevance to group work in health care settings, and examples of their application in these settings. Grounded in these important elements of group work practice, the chapter continues with a review of group work in health care settings, with particular attention to the predominance of problems-based approaches and the need for more strengths-based approaches. Following an overview of the strengths perspective and its relevance to social work with groups, the chapter reviews examples of strengths-based group work practice with vulnerable and oppressed populations in health care settings, including (1) motivational interviewing groups with LGBTQ people abusing substances, (2) nondeliberative

groups with young people experiencing homelessness, and (3) interprofessional practice with various vulnerable and oppressed populations.

TYPOLOGIES OF GROUP WORK

Toseland and Rivas (2012) define group work as “goal-directed activity with small treatment and task groups aimed at meeting socioemotional needs and accomplishing tasks. This activity is directed to individual members of a group and to the group as whole within a system of service delivery” (p. 11). This definition frames the focus of group work: the individual, the group in its entirety, and the group environment (Toseland & Rivas, 2012). This frame presents an important distinction for group work in health care settings, in which practice tends to focus on the individual member and less on the group as a whole and its surrounding environment.

Treatment Groups

Various types of treatment groups are used for various functions within health care settings. In terms of treatment groups, psychoeducational groups provide members with opportunities to gain information regarding their health and well-being through didactic presentations, group discussions, and experiential exercises. Examples might include a tobacco prevention group for young people at a community health center. Following a presentation on risks associated with use, the worker might facilitate a brief discussion for members to process their reactions to the material. Skill-building and growth groups are also content-focused but tend to be more action-oriented, with a strong emphasis on members practicing newly learned skills and behaviors. Examples might include teaching mindfulness exercises for individuals living with terminal illnesses in hospice care or educating expecting parents on prenatal care at a local hospital. Both of these examples would include opportunities for members to rehearse newly learned behaviors, such as deep breathing and healthy eating, respectively.

Therapy groups provide members with opportunities to address behavior change through cognitive-behavioral techniques. For example, a facilitator might work with a group in early recovery from heroin on challenging negative and faulty thinking around methadone maintenance treatment. Therapy groups also provide members with opportunities to explore personal issues through process-oriented techniques, such as working with trans youth as they navigate negative family reactions to their decision to begin hormone treatment. Support groups help members identify coping strategies for dealing with stressful life events, often in a caring and empathic environment, such as a support group for people living with a chronic illness. Self-help groups offer a similarly supportive environment without formally trained facilitators. Examples of these include Alcoholics Anonymous, Narcotics Anonymous, and several other 12-step fellowships. These various types of treatment groups offer members important opportunities to experience all the benefits groups have to offer, including empathy, feedback, mutual aid, and support (Toseland & Rivas, 2012).

Yalom and Leszcz (2005) identify several therapeutic factors to consider when designing and implementing treatment groups in health care settings. Groups offer members opportunities to experience the instillation of hope, a phenomenon that allows members to access and harness their hope by experiencing and witnessing the hopes, dreams, and successes of other group members. Groups also afford members opportunities to experience universality, whereby members' perceived uniqueness is challenged and they ultimately recognize the

commonalities that exist among them. Yalom and Leszcz fittingly refer to this phenomenon as members realizing they are all in the same boat. Groups allow members to experience altruism by creating opportunities for members to help each other work through challenges and accomplish their goals, which is particularly important in groups whose members experience disempowerment. In addition, groups allow members to engage in important forms of imitative behavior, whereby members learn from observing the facilitator's and other members' behaviors in the group. Instillation of hope, universality, altruism, and imitative behavior are all particularly relevant to group facilitation in health care settings, where members are often coping with chronic and life-threatening illnesses and their related physical and psychological side effects. Exploiting these factors allows members opportunities to experience and offer support.

Task Groups

Health care settings also utilize various types of task groups. Teams work collaboratively, often across disciplines, on behalf of the clients they serve. Examples include attending physicians, residents, nurses, social workers, and unit staff meeting weekly to review clients' records on a burn injury unit. Team members often participate in treatment conferences to develop and evaluate patient treatment plans, such as meeting to determine whether clients of an outpatient clinic are meeting their treatment goals. Health care settings hold staff meetings to address administrative tasks, develop goals, and attend to personnel issues. Committees are often established to manage tasks within health care settings, such as a multidisciplinary team charged with hiring new staff. Health care settings also provide staff development trainings on best practices in relevant fields for working with clients. Examples include providing harm reduction and motivational interviewing training for primary care physicians working with young people experiencing homelessness. Although task groups are often time-consuming for overworked health care setting staff, they provide opportunities for medical, nursing, social service, and support staff to engage, experience multiple and alternate points of view, and work toward team-based problem solving and solution development (Toseland & Rivas, 2012).

GROUP DYNAMICS

Group dynamics play an important role in the development and implementation of treatment and task groups in health care settings. Building on the work of early group work scholars (see Coyle, 1930, 1937; Elliot, 1928; Northen, 1969), Toseland and Rivas (2012) identify four dimensions of group dynamics: (1) communication and interaction patterns, (2) cohesion, (3) social integration and influence, and (4) group culture. Group communication and interaction patterns refer to the unique patterns of verbal and nonverbal communication and interaction among group members. While leader-centered patterns are effective at keeping members on-task, group-centered patterns increase members' commitment to group decision-making processes and goals. These patterns evolve throughout the life of the group and influence group cohesion, which is shaped by members' attraction to the group and each other, their capacity to envision the group as a whole, and their ability to work as whole (Forsyth, 2010). In groups with high levels of cohesion, members demonstrate strong attendance, participation, and progress toward goals. Groups with low levels of cohesion experience decreases in member commitment, participation, and attendance.

Social integration and influence refer to members' fit within the group and how the group accepts members' fit (Toseland & Rivas, 2012). This process is influenced by group norms that develop through the interactions of members and guide their behavior across the life span of the group. Members' roles are often shaped by these norms and represent the anticipated behavior of members in relation to a particular function within the group. As norms and roles develop over the course of the group, they both shape and are further refined by group culture. Toseland and Rivas (2012) define group culture as the "values, beliefs, customs, and traditions held in common by group members" (p. 87, citing Olmstead, 1959). The emergence of group culture is often expedited by homogenous group membership, which is described as members having a shared purpose and life experience. Heterogeneous group membership, which is described as members having divergent purposes and life experiences, may slow the development of group culture.

Group communication and interaction patterns, cohesion, social integration and influence, and group culture shape and are shaped by individual members, the group as a whole, and the group environment. Monitoring this dynamic process in treatment and task groups is essential to the life and overall success of the group. Attending to member strengths enhances the development of healthy group dynamics and allows members to experience the benefits of the group process. The following section reviews the use of group work in health care settings, noting the predominance of problems-based approaches and the need for more strengths-based approaches.

A REVIEW OF GROUP WORK IN HEALTH CARE SETTINGS

Early to Mid-20th-Century

Group work developed out of the leisure and recreation movement of the late 19th and early 20th centuries (Meyer, 1934; Pangburn, 1924; Reid, 1981) and community-oriented forms of social work practice, such as those located within the settlement house movement (Andrews, 2001). Rather than focusing on treating individual, family, and community problems, early group work practitioners used activity and other forms of recreation to engage members, increase their communication and cooperation, and build community. Hull House programming during the early 20th century prioritized the use of recreational, art, and music-based groups for young people and adults (*Hull-House Year Book: September 1, 1906–September 1, 1907* [1907]; *Hull-House Year Book: May 1, 1910* [1910], *Hull-House Year Book: 1921* [1921]). These groups provided the community and its members with important opportunities to engage their talents, strengths, and interests (Kelly & Doherty, 2017). As social work became professionalized throughout the early part of the 20th century, a growing majority of group workers were less comfortable with activity-based groups and turned instead to social casework to inform their practice. This trend was particularly prevalent in health care settings.

In reviewing the use of group work in health care settings throughout the 20th century, Getzel (1986) notes, "Social work in health care has a long and close association with social casework, but group work has been used more peripherally" (p. 25). Developed by Mary Richmond, social casework involves the structured diagnosis of individual and family problems, followed by an examination of community factors that contribute to the diagnosed problems (Turner & Jaco, 1996; Wenocur & Reisch, 2001). Once identified, these problems and factors are more fully considered and provide the foundation of what Richmond (1917) defines as a social diagnosis. Once a social diagnosis is identified, the social caseworker

develops a treatment plan that systematically addresses the problems and factors through appropriate interventions. Although social casework may consider individual, familial, and community strengths, the strong focus on problem identification, social diagnosis, and intervention guides the practice model. Given the strong focus on diagnosing individual and family problems, it is clear to see how social casework more closely aligns with medically driven models of intervention prominent in health care settings, where health care professionals seek to diagnose, treat, and care for patients.

Although social casework was the predominant model of social work practice in health care settings in the early and mid-20th century, group work played an important role in health care service delivery and coordination. In her analysis of social work in hospitals in the early 20th century, medical social work founder Ida Cannon (1923) argued that there is clearly room for “*social work with groups* [italics in original] such as we see in the neighborhood associations, settlements, and clubs” (p. 205). Cannon documented the effective use of group work in medical care during this time in her thoughtful analysis of the work of physician Joseph Pratt, who cofacilitated groups with social workers as a means to educate patients about chronic illness, including tuberculosis, diabetes, and heart disease. The group work approach successfully provided patients with important opportunities to share difficulties related to the management of their illnesses and to receive peer and professional feedback in an encouraging and supportive environment. Providing additional context for members’ experiences, Cannon included the following quote from a social worker:

The group treatment helps to build loyalty and cooperation, which brings patients back to the clinic and makes them ready to follow advice. The habit of doing things that are hard or monotonous is much more easily done when others are doing them. New patients soon lose their shyness; those consumed in self-pity seldom fail to find others making less of greater handicaps; and the discouraged man or woman hears how someone else gained when conditions seemed quite hopeless. (pp. 76–77).

It is important to note the presence of group dynamics and therapeutic factors in the social worker’s assessment of this early form of group work in a health care setting, specifically group cohesion as evidenced in members’ loyalty and cooperation, and hope and universality in their realizations that they are not alone.

Mid-20th-Century to the 2000s

In her review of social work in health care settings, Bartlett (1961) noted the growing importance of group work for social workers in the health care field. Getzel (2006) notes that the use of groups in health care settings increased during the 1960s and that groups were used extensively in the treatment of behavioral health disorders throughout this time as well. Frey (1966) developed the first systematic review of group work in health care settings and found that groups were often developed and implemented to fulfill the needs of larger organizational structures of the health care settings and systems in which they resided. Getzel (1986) makes a similar observation in his analysis of social work groups in health care settings, labeling this trend the *compliance-marketing model*, whereby “organizational considerations predominate” and “the group reflects the hierarchical organization structure of the large health care system with clients in subordinate position to the social workers and other professionals and social workers subordinate to physicians” (p. 26).

Rosenberg and Neil (1982) reviewed 51 articles on group work in health care settings published between 1964 and 1979 and found that the majority of groups were cofacilitated

(e.g., by a social worker with a nurse or physician) and formed around client illness with the primary purpose of supporting medical treatment through client and family education. Getzel (1986) updated this analysis, reviewing 38 additional articles on group work in health care settings published between 1978 and 1982 and found similar trends in the literature, adding “few groups dealt with the context of changing the patient’s environmental conditions, in or outside the hospital” (p. 28). Speaking to this gap, Schopler and Galinsky (1990) posited that groups have the potential to humanize growingly complex and expensive health care systems in cost-efficient ways and to provide clients with important opportunities to experience mutual aid and support.

In a review of the use of groups in health care settings during the 1990s and early 2000s, Getzel (2006) argues for a “disregard of the Cartesian mind-body dichotomy by simultaneously addressing health and mental health as a focus for social work with groups” (p. 195). Findings from his review demonstrate the use of groups in addressing chronic and complex illnesses, including sickle cell disease, cancer, severe and persistent mental illness, and HIV/AIDS. The use of cognitive-behavioral approaches was prevalent in the field during this time, as the use of activity-based groups continued to lose favor in the rapidly growing field of evidence-based practice. Groups also played an important role in staff supervision, support, and collaboration during this time, as models of multidisciplinary teams and practice are described and evaluated in the literature.

Current Uses

A review of the recent literature on group work in health care settings demonstrates similar trends in the field. Cognitive-behavioral groups are used in addressing cancer and its related effects. In a longitudinal experimental study, Antoni and colleagues (2006) found cognitive-behavioral groups to be effective in reducing intrusive thoughts and anxiety with women undergoing breast cancer treatment 1 year past group participation. Cohen (2010) presents a practice-informed cognitive-behavioral model developed in Israel that focuses on reducing emotional distress in cancer patients and increasing their skills in coping with the illness and chemotherapy over the course of six meetings.

Support groups are used internationally in helping clients and their families cope with the effects of cancer. In a descriptive study from Australia, Butow and colleagues (2006) found leaders’ facilitation skills and educational and personal qualities contribute to effective leadership in support groups for cancer patients. In a qualitative study from Australia, Ussher, Kirsten, Butow, and Sandoval (2008) explored factors related to cancer support group attrition and nonattendance. They report that lack of referrals or knowledge of groups, existing forms of support, and resistance to a cancer patient identity influence respondents’ decisions to participate in cancer support groups. Lounsberry, MacRae, Angen, Hoerber, and Carlson (2010) longitudinally investigated the effects of a telehealth videoconferencing group for survivors of allogeneic hematopoietic stem cell transplant in Canada. Findings suggest that although participants gain some benefit from participation, they do not report any significant improvements. In a cross-sectional study exploring the use of financial incentives in support groups for children with cancer in India, Srinivasan, Tiwari, Scott, Ramachandran, and Ramakrishnan (2015) found that participants who are not provided with incentives are more likely to abandon cancer treatment after initiating therapy.

Groups continue to be used in addressing chronic illnesses and their related effects. In an intervention research study, Comer (2004) worked with an interdisciplinary team of health care providers to facilitate cognitive-behavioral groups using self-management

techniques for clients living with sickle-cell disease and depression. Findings demonstrate that group members reported a decrease in symptoms related to their depression. Vail and Xenakis (2007) facilitated expressive writing and assertiveness training groups for women living with disabilities. Results from self-administered surveys suggest members appreciated the opportunity to explore their issues and learn new skills. Charlton, Gabriel, Munsinger, Schmaderer, and Healey (2010) evaluated the feasibility and effectiveness of a modified exercise group for people living with multiple sclerosis. Findings suggest that participants enjoyed the group and experienced improvements in their physical and mental health.

Céspedes-Knadle and Muñoz (2011) describe the development and implementation of a group for young people with type 1 diabetes and a parallel support group for their caregivers. The proposed group intervention is designed to improve young people's psychosocial well-being and medical adherence, whereas the support group is designed to reduce caregiver stress. Hess (2011) presents a practice-informed psychoeducational group treatment for clients with noncardiac chest pain, many of whom live with chronic anxiety and panic disorders. The proposed model offers members opportunities to challenge their faulty beliefs and learn new breathing techniques and coping skills to break the cycle of panic and anxiety.

Groups are employed in substance use treatment and recovery. Little and Franskoviak (2010) describe the use of harm-reduction drop-in groups in community settings, including primary care clinics. Practice-informed findings from their work with over 1,000 clients suggest these groups help reduce the harmful effects of drug use, stabilize psychiatric symptomology, and as a result often lead to permanent housing placements. Garte-Wolf (2011) describes the use of narrative therapy in groups for people living with HIV who are also in recovery from addiction. Findings suggest the reframing technique found in narrative therapy and the relational process and mutual aid found in group therapy combine to create supportive, less stigmatizing environments than traditional 12-step recovery groups.

There is increasing attention on the use of parenting groups in health care settings. Berge, Law, Johnson, and Wells (2010) piloted a 2-week parenting psychoeducational group in a primary care clinic in an underserved urban area. Participants experienced significant improvements in managing child behavior problems and overall family functioning. In addition, findings suggest the model may be useful and replicable in other primary care settings interested in offering similar parenting training services. Knox, Burkhart, and Cromly (2013) evaluated effective parenting training groups in health care settings and found the groups increased positive parenting behaviors. This suggests that health care settings may be an effective place to train parents in positive parenting skills, which may lead to reduced rates of child maltreatment.

In an essay, Drum, Swanbrow Becker, and Hess (2011) identify the evolving nature of the health care marketplace, increases in chronic conditions, and the rising prominence of health psychology as important factors in the increasing prevalence and relevance of groups in health care settings. They offer the following guidelines as a conceptual framework for developing group interventions in health care settings:

1. Make the change strategy explicit.
2. Give explicit consideration to the composition of the group.
3. Consider use of facilitative conditions (i.e., therapeutic factors).
4. Consider to what degree the interpersonal group process is facilitated.
5. Consider key elements of the intervention.

In describing the key elements of the intervention, they ask the questions, “What are the hypothesized key informational deficits, faulty beliefs, emotional barriers/fears, or other factors that prevent participants from naturally coping effectively with this disease or condition? How does the change strategy help them overcome/cope more effectively with these factors?” (Drum et al., 2011, p. 261).

Much of the reviewed literature considers members’ health-related problems as the primary purpose and focus of group work in health care settings. Reviewed group models offer members and their families training and/or support in coping and living with their health-related problem(s) and its related effects. Even those models that attend to the development of group dynamics and the exploitation of therapeutic factors tend to do so from a problems-based perspective (i.e., treating the disease/problem and its related effects). It is unclear if and how groups in health care settings consider members’ strengths. Of the literature reviewed, only one theoretical model explicitly emphasized clients’ strengths and focused on their empowerment (Cohen, 2010). While the setting and context of group work in health care settings may suggest an inherently problems-based approach, there is clearly room in the literature to propose and explore strengths-based approaches, particularly with vulnerable and oppressed populations in health care settings. The following section reviews the strengths perspective and places it within the context of social work with groups.

THE STRENGTHS PERSPECTIVE AND SOCIAL WORK WITH GROUPS

Building on the strengths-based approaches practiced in the settlement house movement (*Hull-House Year Book: September 1, 1906–September 1, 1907* [1907]; *Hull-House Year Book: May 1, 1910* [1910], *Hull-House Year Book: 1921* [1921]) and further developed and refined in social group work (Coyle, 1930, 1937) and humanistic (Rogers, 1957) and social constructivist (White & Epston, 1990) psychology, the strengths perspective suggests that all individuals have inherent abilities and capacities and that, regardless of presenting challenges, it is the practitioner’s duty to recognize and work with these strengths. Saleebey (2012) outlines several principles of the strengths perspective, including:

1. All client systems, including individuals, groups, families, and communities, have strengths.
2. While presenting challenges may be harmful (e.g., abuse, illness, and or trauma), they may also be opportunities for growth.
3. Never assume the upper limits of client systems’ capacity for growth and change.
4. Client systems are best served through collaboration.
5. All environments, regardless of perceived deficiencies, are full of resources.

Lietz (2007) stresses the importance of incorporating the strengths perspective in social work with groups, noting the potential to address factors related to group cohesion, including members’ negative attitudes toward the group, poor attendance, and early termination. Hudson (2009) incorporates the principles of the strengths perspective in empowerment-based models of social work with groups, and Moyse Steinberg (2014) makes similar connections between the mutual aid model for social work with groups and the strengths perspective. Malekoff (2014, p. 43) applies the strengths perspective to group work with adolescents, articulating seven evidence-guided practice principles:

1. Form groups based on members' felt needs and wants, not diagnoses.
2. Structure groups to welcome the whole person, not just the troubled parts.
3. Integrate verbal and nonverbal activities.
4. Develop alliances with relevant other people in group members' lives.
5. Decentralize authority and turn control over to group members.
6. Maintain a dual focus on individual change and social reform.
7. Understand and respect group development as a key to promoting change.

Malekoff (2014) notes, "the principles are overlapping and interrelated" (p. 50), and they are essential components of group work practice with young people "regardless of the practitioner's theoretical or ideological orientation" (p. 43). Although Malekoff frames the principles within a model of strengths-based group work with adolescents, as the following examples demonstrate, these principles may also be applied to group work with vulnerable and oppressed young people and adults through a variety of theoretical orientations/perspectives and practice settings.

MOTIVATIONAL INTERVIEWING GROUPS FOR LGBTQ PEOPLE

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) people are disproportionately represented in substance-abusing populations (McCabe, West, Hughes, & Boyd, 2013). Historically, social pressures for sexual orientation and gender identity conformity shaped opportunities for LGBTQ people to socialize, often limiting their options to bars, clubs, and cruising areas where substance use was often the norm (Boyd, 2003; Chauncey, 1994). Easy access to alcohol and other drugs in these spaces often served as a coping mechanism for LGBTQ people to manage internalized homophobia and transphobia and to cope with overtly hostile and at times violent forms of homophobia, transphobia, and heterosexism. While acceptance of LGBTQ people has increased over time, the combination of internalized homophobia and transphobia, institutional stigmatization, and discrimination against LGBTQ people may continue to contribute to disproportionate rates of LGBTQ substance abuse (McCabe et al., 2013). LGBTQ people also experience barriers to substance use treatment, including internalized homophobia and transphobia; homophobic, transphobic, and heterosexist attitudes and practices among substance use treatment providers; and overall deficiencies in LGBTQ-affirming substance use treatment (Cochran, Peavy, & Robohm, 2007).

Strengths-based approaches to group work offer LGBTQ people important opportunities to engage in substance use treatment in an affirming environment. Strengths-based psychoeducational, skill-building, and growth groups offer LGBTQ people who abuse substances opportunities to learn about the health effects of their drug use, methods to reduce the harm of their use, coping skills and strategies for managing internalized homophobia and transphobia, and advocacy skills for combating oppression that may be contributing to their use. Strengths-based therapy groups provide members with opportunities to affirm and celebrate their sexual and/or gender orientation and to explore opportunities to liberate themselves from negative thinking as a result of institutional homophobia, transphobia, and heterosexism. Support and self-help groups offer LGBTQ people who abuse substances opportunities to explore their use and decisions about recovery in caring, empathic, and supportive environments.

Although not explicitly framed as a strengths-based approach to substance use treatment, motivational interviewing incorporates several principles of the strengths perspective. Developed by Miller and Rollnick (2013) to address limitations in alcohol abuse treatment, motivational interviewing assumes that all clients are responsible for and capable of change and that it is the worker's role to facilitate conditions in order to enhance clients' motivation for and commitment to change. The goal of motivational interviewing is to explore clients' ambivalence toward change efforts and to identify appropriate interventions that match their current level of readiness to change. The spirit of motivational interviewing incorporates several principles of the strengths perspective, including the worker's unconditional recognition of clients' absolute worth, affirming clients' experiences, and practicing deep acceptance and compassion for clients. The worker's role in motivational interviewing is to express empathy for clients, develop discrepancies within their narrative, avoid argumentation, roll with resistance, and support clients' self-efficacy. The worker accomplishes this by asking clients open-ended questions, affirming their efforts to change, listening reflectively, and summarizing.

As the following brief example demonstrates, motivational interviewing offers opportunities to address the strengths of LGBTQ people who abuse substances. At the outset of a group session exploring the effects of alcohol and other drugs at an LGBTQ community health center, the facilitator welcomes participants and informs them that all are welcome, regardless of their level of use and/or resistance to looking at their use. As the session gets under way, some members begin to express ambivalence about engaging in a discussion about the effects of their alcohol and drug use, arguing that it is their only social outlet and that they are unwilling to give it up. Rather than argue with members and challenge their resistance, the facilitator lets the members know he or she hears them, reflects back their concerns about losing something that is important to them and their social environment, and moves the discussion along, looking for opportunities to engage the members in a productive, nonconfrontational exchange. As the session continues, some of the same members discuss negative health effects they have experienced as a result of their use, including loss of sleep, poor diet, and sexually transmitted infections. Here, the facilitator pauses and highlights the discrepancies in the members' statements: They do not want to change their alcohol and drug use, yet they are experiencing negative health effects as result of their use.

From here, the facilitator may work with members to identify any changes the members are willing to make in their use, remaining fully sensitive to members' attachment to their alcohol and drug use as a means of social engagement and perhaps as a coping mechanism for internalized and/or systemic oppression. By listening to members' needs and wants and recognizing their self-worth, facilitators will experience greater success in identifying realistic change goals that are sensitive to the needs of LGBTQ people. In doing so, the facilitator welcomes the whole person, never assumes their capabilities or capacities, and collaborates with the group members.

NONDELIBERATIVE GROUP WORK WITH YOUNG PEOPLE EXPERIENCING HOMELESSNESS

Over half a million young people experience an episode of homelessness for 1 week or more annually (National Alliance to End Homelessness, 2014). Given this prevalence, the majority of the literature on homeless youth is framed from a risks-and-consequences perspective.

Research focuses on identifying populations of young people at risk for homelessness, including young people who identify as LGBTQ (Ray, 2006) or who experience trauma (Coates & McKenzie-Mohr, 2010) or family conflict (Alvi, Scott, & Stanyon, 2010). Research also focuses on examining the consequences young people experience as a result of being homeless, including increased health problems (Beharry, 2012), exposure to violence (Finkelstein, 2005), sexually transmitted diseases (Kennedy, Tucker, Green, Golinelli, & Ewing, 2012), and substance use (Ferguson & Xie, 2012). A growing body of qualitative research challenges this risks-and-consequences perspective by exploring the survival narratives of homeless youth and framing their narratives as demonstrations of strength and resilience (Bender, Thompson, McManus, Lantry, & Flynn, 2007; Karabanow, Hughes, Ticknor, Kidd, & Patterson, 2010; Kidd & Davidson, 2007; Kidd & Evans, 2011).

Lang (2016) proposes a model of nondeliberative group work, which is well suited to creating opportunities for young people experiencing homelessness to explore and express their strengths. Nondeliberative practice is a creative, intuitive, and spontaneous form of group work that emerges from members' lived experiences. It employs "artful, actional and analogic forms of solution-seeking" (Lang, 2016, p. 103), such as dance, drama, games, music, and the visual arts, in an effort to engage members in cognitive and conative methods of problem solving. The purpose of the use of activity in nondeliberative group work is to do and then think. Members are invited to participate in the group process and consider how the process applies to other areas of their lives. Through this theoretical lens, the worker's role is to identify activities that further the work of the group and facilitate the group process.

Kelly (2013) explored the use of a music studio in a transitional living program for young people experiencing homelessness and found that young people's engagement with the studio and affiliated projects brought out their strengths. In one of those affiliated projects, Kelly (2015) coproduced an audio documentary with some of the same young people. The audio documentary group incorporated the artful, actional, and analogic forms of solution seeking found in nondeliberative group work practice. As a result, members not only coproduced an audio documentary but also engaged in a dynamic group process that engaged their strengths and provided them with opportunities to consider how their strengths might apply outside the group (Kelly & Hunter, 2016).

The same agency provides health care for young people through its onsite clinic, which is staffed by a nurse practitioner. Access to an onsite music studio and health care clinic provides unique opportunities to explore nondeliberative, audio-based group work practice with young people experiencing homelessness. For example, residents are required to attend weekly life skills groups, which include sessions on health and well-being facilitated by the onsite nurse practitioner. As part of the group, the nurse practitioner and young people might work together to compose a song. In doing so, the nurse practitioner presents young people with an opportunity to address something through activity (e.g., songwriting) that may be seemingly unrelated to or beyond the scope of a presenting issue (e.g., learning new skills for health and well-being, such as safe sex practices or smoking cessation). As members engage in the activity and identify creative solutions, they have opportunities to reflect upon problem resolution in relation to the activity and how their experiences may relate to other issues in their lives (e.g., young people develop a song about health and well-being and subsequently may develop additional creative solutions for making decisions about safe sex and smoking cessation outside the group). In addition, it provides young people with opportunities to engage their music-related talents, strengths, and interests.

INTERPROFESSIONAL PRACTICE WITH VULNERABLE AND OPPRESSED POPULATIONS

Although the majority of literature exploring the use of groups in health care settings tends to focus on client/patient-centered groups, some literature explores the use of team-based interprofessional practice in health care settings. Interprofessional practice involves health care workers from various professional backgrounds working together in a coordinated fashion with patients, families, caregivers, and communities to deliver the highest quality of care. Interprofessional practice teams are often intentionally created, relatively small work groups of health care professionals who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or a group of patients. Roles within an interprofessional health care team may include physicians, psychiatrists, psychologists, nurse practitioners, registered nurses, social workers, care coordinators, dietitians and nutritionists, community mental health workers, and clinical coordinators. Examples of interprofessional teams within health care settings include rapid response teams, palliative care teams, primary care teams, operating room teams, and community-based mental health teams.

Several studies have explored the use of interprofessional practice with vulnerable populations. Westheimer, Capello, McCarthy, and Denny (2009) explored the use of doctor interactive group medical appointments (DIGMAs) with hypertensive male veterans. Findings indicate participants' blood pressure was reduced significantly between pre- and posttests and that participants increased their health-promoting behavior. Counsell and colleagues (2007) evaluated an interprofessional practice model for assessment and care coordination of low-income seniors. In this model, a certified nurse practitioner and a clinical social worker complete an in-home, comprehensive assessment of the patient and collaborate with an interprofessional team to develop individualized care plans. Findings indicate patients reported significant improvements in general health and had reduced emergency department visits. In addition, high-risk participants had lower admission rates when compared with the treatment-as-usual group.

Tataw, James, and Bazargan (2009) present the conceptual framework for an interprofessional practice program that addresses the financial and nonfinancial aspects of health care access and health status for low-income urban children and families in South Central Los Angeles. Using educational and case management strategies, the program is designed to increase health services utilization, improve preventive health techniques, and boost disease self-management, with the ultimate goal of attaching children to medical homes. In 2010 the Veterans Health Administration launched the Patient-Aligned Care Team (PACT) model to transform the way military veterans receive their care (U.S. Department of Veterans Affairs, 2015). The PACT model is built on the well-known concept of a patient-centered medical home staffed by interprofessional teams. The goal of PACT is to provide patient-driven, proactive, personalized, team-based care oriented toward wellness and disease prevention in an effort to improve veteran health care satisfaction, health outcomes, and costs.

Assertive Community Treatment (ACT) is an evidence-based mental health service delivery model that combines treatment, rehabilitation, and support for severely mentally ill individuals. ACT is provided by multidisciplinary teams, which often include psychiatrists, nurses, social workers, and rehabilitation counselors who are available 24 hours a day, 7 days a week, thereby creating an intensive approach model to community mental health services. ACT has been found to reduce hospitalizations, increase housing stability, reduce

symptomology, improve quality of life, and engage severely mentally ill individuals in treatment (Bond, Drake, Mueser, & Latimer, 2001). Forensic ACT (FACT) is an adaptation of the ACT model. It serves individuals with serious mental illness who are also involved with the criminal justice system. FACT programs differ from ACT programs in several ways, including the prioritization of services to prevent recidivism and incarceration and the greater use of legal leverage (Lamberti, Weisman, & Faden, 2004). In addition, models may incorporate residential substance abuse treatment, supervised residential settings, and the inclusion of a probation officer on the FACT team (Lamberti et al., 2004).

Of the models reviewed, only ACT programs explicitly incorporate strengths-based approaches in interprofessional practice (McGrew & Bond, 1995). Furthermore, there is little information in the literature regarding the use of strengths-based approaches within interprofessional practice teams and their management. Rather, the literature offers recommendations on the levels of integration in interprofessional care, where greater integration of services and systems leads to greater level of care (Heath, Wise Romero, & Reynolds, 2013). Additional literature notes challenges in developing and implementing interprofessional practice teams, including conflict among team members and their respective disciplines, lack of team culture and leadership, and the lack of organizational support (Tataw, 2011). Increased attention to strengths-based approaches in interprofessional practice in health care settings may offer important benefits. Developing and implementing healthy, respective, and communicative interprofessional teams in supportive organizational environments may lead to greater levels of care integration, which will positively affect the health and well-being of the clients teams serve (Heath et al., 2013).

CONCLUSION

As this chapter demonstrates, groups are used extensively within health care settings. While social casework may have been the predominant model of social work in health care settings in the early 20th century, groups played an important role in health care service delivery and coordination during that time. Groups continued to play an important role in health care settings throughout the 20th century and continue to do so today, albeit from a problems-based orientation. There is a need for more strengths-based approaches in group work in health care settings, particularly with vulnerable and oppressed populations. Motivational interviewing groups, nondeliberative group work practice, and interprofessional practice teams are but a few accessible, collaborative, and creative ways to incorporate greater attention to members' inherent strengths.

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CHAPTER 13

Evidence-Based Group Work in Mental Health Practice

MARY C. RUFFOLO
CAROLYN M. MAKER

The field of mental health treatment and services has used group work interventions as one of the primary ways to intervene with youth, adults, and families living with mild to significant mental health challenges. The group interventions may focus on prevention, psychoeducation and support/self-help approaches, or treatment/recovery approaches.

Group work interventions that focus on prevention and psychoeducation may be time-limited, use structured session formats, and apply strategies that promote increasing knowledge of the illness, as well as coping and problem-solving skills. The goal of prevention and psychoeducational groups are “to reduce the incidence of future harm and facilitate health promoting and risk reducing behaviors” (Merchant & Yozamp, 2014, p. 6). The support group work approaches are often led by consumers or family members and employ an open group membership format. Support groups provide emotional support and information to group participants. Self-help groups are often defined as “supportive, educational, usually change oriented mutual aid group that addresses a single life problem or condition shared by all members” (Kurtz, 1997, p. 4). Treatment/recovery approaches emphasize engaging youth and adults in remedial or recovery or empowerment-oriented change strategies to improve the quality of life for participants living with significant mental health/psychological problems and may use a time-limited structure or an ongoing support and recovery structure.

Group work interventions may be delivered in outpatient behavioral health settings, in schools, at hospitals, in the community, and at a range of specialty health, mental health, and addiction program settings. The integrated health initiatives of the past few years create even a greater opportunity for growth in the delivery of group work interventions to address the needs of individuals and families living with mental illnesses and chronic health conditions. In addition, there is an emerging body of evidence that supports the use of the Internet and Web-based technologies to deliver group work interventions to adults living with mental illnesses and their families or caregivers.

Some of the appeal of the use of group work interventions in the mental health field is that these groups have the potential to serve more youth, adults, and families in a cost-efficient manner when compared with individual or family therapy approaches.

The evidence to support group work interventions varies based on the theoretical approaches used and the specific behavioral health diagnoses. In the following excerpt from the Association for Group Psychotherapy website (www.agpa.org/home/practice-resources/evidence-based-group-practice), we see how this organization reflects on the evidence that supports the use of group work in treatment for individuals living with mental health disorders:

During the last 30 years, studies have shown the growing benefits of group psychotherapy in a number of areas of life challenges. Through groups, individuals find a forum of peer support, gaining strength as they share their feelings and experiences with others who are facing the same obstacles as themselves. Some gain strength in seeing the resourcefulness of those in the same situation, while others renew their feelings of self-worth through assisting others.

During the group process, people develop a support network through each other—no longer feeling isolated by their condition and gaining a greater sense of normalcy. With certain medical conditions, group psychotherapy can contribute to general improvement in one's psychosocial functioning. Research also has shown that survival rates have, in some cases, actually increased, with proper therapy. Research has demonstrated that various forms of group psychotherapy are equally beneficial with positive results found across the board for a variety of disorders. Group therapy is also cost-effective when compared to individual treatment. When a therapist's time is spent with an entire group instead of one person, the expense for individuals is significantly reduced while the benefits remain and, in some instances, prove to be even greater.

In a review of several meta-analytic findings from control and comparison groups on the efficacy of group psychotherapy, we do know that a majority of group participants demonstrated improved outcomes and are better off than those who did not engage in group interventions (Burlingame, Fuhrman, & Mosier, 2003).

EVIDENCE-BASED GROUP WORK

Evidence-based group work (EBGW) is defined as “a process of the judicious and skillful application in group work of the best evidence, based on research merit, impact and applicability, using evaluation to ensure that desired results are achieved” (Macgowan, 2008, p. 3). In this chapter we highlight EBGW practices that have the best evidence for particular populations of youth or individuals living with mental health challenges, that have been studied using rigorous methods, and that have demonstrated positive outcomes for participants. According to Macgowan (2008), EBGW practice involves being willing to engage in critical inquiry of beliefs and practices, systematically collecting and appraising evidence, acknowledging that science and practice are interrelated, assessing group processes and outcome, and building on group worker knowledge and skills.

For most group workers, we engage in EBGW practice process when we begin to ask ourselves what we know from research and practice about the best way to deliver group work interventions to a particular set of clients or consumers. For example, you are working in an outpatient behavioral health setting with adults living with schizophrenia or bipolar

disorders. You and your team members have thought about starting a treatment/recovery-focused group to help these individuals. Several of the adults are isolated and also have trouble coping on a day-to-day basis with routine tasks. Exploring the research literature to find out what groups have been developed and evaluated that focus on similar issues or themes would be an important first step.

In another example from a child-focused mental health setting, you and your co-group leader note that the group intervention that is currently being used at your agency for parents of youth with attention-deficit and hyperactivity disorders is not working. Parents drop out in the early stages of the group engagement process. If you and your co-group leader are using EBGW processes, you might engage in reevaluating what evidence supports your current agency group work approach and whether there are other group work interventions that have been demonstrated to work better for this population of parents.

With this EBGW mind-set, in this chapter we explore what is known through research about what works for youth and individuals living with mental health challenges. We highlight some key evidence-supported approaches that address core psychological problems experienced by youth and adults living with a mental illness. In addition, we explore some of the key challenges in sustaining EBGW interventions over time. While we recognize that understanding what we know from research is just one of the critical steps in EBGW, we also encourage you to critically evaluate the research based on your own understanding of the clients/consumers your organization serves.

THE TARGET POPULATION

In this chapter we focus our review on EBGW practices for youth and adults living with a mental health disorder and their families or caregivers.

Adults

In the United States, 1 in 5 adults will have a diagnosable mental health condition in any given year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). In addition, 50% of Americans will meet the criteria for a diagnosable mental health condition sometime in their lives, and half of those people will develop conditions by the age of 14 (Kessler et al., 2005). The risk for serious mental illness, especially schizophrenia, bipolar disorder, and attention-deficit/hyperactivity disorder (ADHD), is linked to heredity/genes for 17–28% of the population (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013). Individuals who are exposed to adverse childhood events—including abuse, neglect, divorce, witnessing domestic violence, and having parents who have substance use issues, mental illnesses, or are in jail—are (1) 2.6 times more likely to have depression, (2) 5 times more likely to have serious alcohol problems, (3) 17 times more likely to have learning or behavioral problems, and (4) 3 times more likely to have serious job problems (Burke, Hellman, Scott, Weems, & Carrion, 2011). Individuals with any mental illness are (1) 2.3 times as likely to develop nicotine dependence, (2) 3 times more likely to develop alcohol dependence, and (3) 30 times more likely to develop illicit drug dependence (Swendsen et al., 2010). The stigma associated in the United States with being diagnosed with a mental health disorder often discourages individuals from seeking treatment and services for their illnesses. The current approach to working with adults living with mental illness is to support

recovery. SAMHSA's (2012) working definition of recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Children and Adolescents

Recent data show that for children between the ages of 8 and 15 years, 13.1% were diagnosed with a mental health disorder within the past year (National Institute of Mental Health [NIMH], 2010). The most common diagnoses included ADHD at 8.5%, mood disorders at 3.7%, and major depressive disorder (MDD) at 2.7% (NIMH, 2010). In the United States, 20% of children and adolescents currently, or at some point in their childhood, have been diagnosed with a mental health disorder (NIMH, 2010). The need for mental health services for children, adolescents, and their families is especially high, especially since studies have shown that the prevalence of these disorders is increasing (Landy & Bradley, 2013). Children, adolescents, and their families experiencing mental health disorders face challenges, including stigma, isolation, discrimination, and decreased access to education and health care facilities (World Health Organization [WHO], 2015).

The target population of youth and adults living with mental illnesses is racially, culturally, and linguistically diverse and requires a range of preventive, intervention, and recovery-oriented EBGW services.

Key Steps to Guide EBGW for This Target Population

EBGW practices for this target population require that the group work leaders employ some key steps to guide the group work intervention process. These key steps of group work practice cross the spectrum from prevention to recovery in the mental health field. Underlying these steps is "the recognition that issues of multiculturalism and social justice affect group process and dynamics, group and individual outcomes, facilitation, training, and research" (Singh, Merchant, Skudrzyk, & Ingene, 2012, p. 2). The key steps involve effective planning, organizing and forming the group, selecting and applying change strategies, and assessing the effectiveness of the group intervention.

In *effective planning*, the group leaders need to determine what type of group is needed (e.g., prevention, psychoeducation, support, therapy, recovery) to address the needs of the target population. It is important in this step to consider the unique diversity factors present in the target population that you wish to engage in the group process. The goals for the group work intervention need to be established early in this process, and best practices based on current research, practice wisdom, and target population preferences need to be reviewed. Group sessions should be outlined and specific group interventions detailed before recruiting members for the group. Once the planning is completed, then the next step is to engage in organizing and forming the group.

The *organizing and forming the group* step is crucial to the successful implementation of the group work intervention. Rapin and Crowell (2014) identify several key organizing elements in the formation of a group. These elements include professional and regulatory requirements, time, management support, manpower, materials, money, and supervision. In agency or practice settings in which groups are an add-on to usual practice, sustaining the groups over time often becomes difficult. In this step, reviewing the supports present to implement the group will facilitate the likelihood that the group will be implemented. In this

step you also need to decide how the group will be marketed, what screening procedures will be used, and whether the group will be an open or closed group.

The next step, *selecting and applying change strategies*, involves being flexible and theory driven and employing a range of change strategies to foster engagement and commitment of participants to the group work process. Primarily emerging from work with psychotherapy groups, Yalom (2005) identified 11 therapeutic factors considered to be important in the process dynamics during group sessions. The 11 therapeutic factors include: (1) instillation of hope, (2) universality, (3) imparting information, (4) altruism, (5) recapitulation of the primary family group, (6) development of socializing techniques, (7) imitative behaviors, (8) interpersonal learning, (9) group cohesiveness, (10) catharsis, and (11) existential factors. In this step, the group leader is paying attention to process and goals for each session. Balancing the work of the entire group with the needs of individuals is critical.

In the final step, *assessing the effectiveness of the group intervention*, the group leader needs to engage in using process and outcome measures. Process measures can be collected at each group session and may focus on engagement of participants in the group, participant satisfaction with the group focus, acceptance by the group, and other process variables. The outcome measures can be collected using a pre-post measure approach that captures change around the specified group goals, and this measure can be completed before the start of the group, at the end of the group, and at designated follow-up time points. It is also important to assess whether the EBGW practice was delivered with fidelity. The group leader takes this evaluation information and adapts the group intervention based on this feedback loop.

In the next sections in this chapter, we illustrate the EBGW process by highlighting a few EBGW practices for adults and youth living with mental health challenges. We focus on multiple family group psychoeducation for adults living with schizophrenia and their families, cognitive-behavioral approaches for working with youth with a range of mental health disorders, and parent management and support approaches in working with parents of youth living with serious mental health challenges.

MULTIPLE-FAMILY PSYCHOEDUCATION GROUP WORK APPROACH

Case Example

You are a clinician who is working in a community-based mental health agency that serves primarily adults living with serious mental illnesses. Many of the individuals your agency serves are often hospitalized when they stop medications, live in unstable living situations, have distant or conflictual relationships with family and friends, and have trouble maintaining jobs. A majority of the individuals identify as African American or Caucasian. The community has high unemployment rates and scarce resources to support individuals who end up homeless or without a stable income. Your agency uses Assertive Community Treatment teams with the individuals who are experiencing the most severe mental health challenges. You have noticed that over the past several months many of the individuals that you work with are not able to maintain a stable housing or employment situation, and that these individuals have been diagnosed with schizophrenia. They also are young (the males are in their early 20s and the females are in their mid-20s). Several have been hospitalized at least two times in the past year. The current practice is to see these individuals in individual counseling sessions one or two times a month and to refer them to case management services to assist with concrete resources.

Effective Planning

The first step as an EBGW practitioner is to discuss with your team these observations that you have made and to seek additional data from the management information system and other workers to determine whether others also have seen this trend. Once you have established that this target population is in need of different or enhanced services, then you would begin engaging in the first step of effective planning. You begin to search the literature for best practices for working with this population and to examine what types of individual, group, or family interventions are effective. You also explore what approaches have been used in your agency in the past as it relates to this population. You seek input from individuals experiencing problems with getting needed help for the treatment of schizophrenia. In this search you identify an evidence-based practice that has demonstrated positive outcomes for individuals living with schizophrenia in helping to improve compliance with medications, decreasing hospitalizations, and improving relationships with family and significant others. The EBGW practice is multiple family psychoeducation, and it is identified by SAMHSA as one of the key evidence-supported practices for working with individuals living with schizophrenia. You also note that this practice has a toolkit that operationalizes the steps needed to plan for delivery of this intervention, what happens in each session, and ways to measure fidelity and outcomes. The toolkit can be found at the following link: <http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423>.

The multiple family psychoeducation group (MFG) model is an evidence-based practice that has been shown to reduce relapse rates and facilitate recovery of persons who are living with schizophrenia or other schizoaffective disorders. According to Dixon and colleagues (2001), the critical ingredients or core elements of MFG include (1) education about serious mental illnesses, (2) information resources, especially during periods of crises, (3) skills training and ongoing guidance about managing mental illnesses, (4) problem solving, and (5) social and emotional support.

According to the SAMHSA toolkit, the MFG model has three distinct phases: joining, education, and ongoing problem solving. In the joining sessions, which may occur over three to four sessions, participants build a working alliance with the group leaders and discuss their experiences with mental illness, their goals, and some of their strengths and challenges/barriers. The education phase focuses on providing group members with information about schizophrenia, the brain, family guidelines, medications, and other relevant information related to living with mental illness in the family. The ongoing problem-solving phase emphasizes a structured process in which group participants engage in problem-solving challenges they experience in coping with their mental illness on a day-to-day basis. All group participants (including family members) generate possible solutions. Some of the typical types of problem areas covered in the problem-solving sessions may focus on medication compliance issues, health concerns, housing situations, work or education problems, family communication issues, feelings of isolation, substance misuse, transportation issues, or other emotional or concrete issues.

The MFG model involves meeting two times a month for 1 hour and 30 minutes. The structure of a typical MFG session involves an initial chat time during which participants socialize at the start and end of the group sessions, followed by a go-round in which participants share one aspect of their lives that is going well and one challenge they are experiencing since the last group session. Then the group leaders select one of the challenges for problem solving by the group. The problem-solving phase usually lasts around 45 minutes.

The problem-solving component includes the following steps: (1) A problem is defined for work. (2) A minimum of 8 to 10 possible solutions are brainstormed. (3) Each solution is evaluated by identifying positive and negative aspects of it. Finally, (4) the participant whose problem is the focus of the session selects the solution that will be worked on in between group sessions. Oftentimes, food is provided at the group sessions for the socialization phase of the session.

Organizing and Forming the Group

Using the SAMHSA toolkit as a guide, you would begin to address organizational issues that can facilitate or create barriers to implementation of the MFG. In your organization, as is typical in most mental health settings, the usual way to deliver treatment to high-risk populations is through individual approaches and most often does not include family members. The MFG model changes this structure from individual to more of group treatment and from excluding families to including them as a core component of the group intervention. Selecting group leaders to deliver the MFG model requires funds to secure training and ongoing supervision of these group leaders. The SAMHSA toolkit provides the core manual with the process steps identified, and it also includes fidelity measures to ensure that your organization will be delivering the MFG model with integrity. Your organization will also need to assess whether there are enough individuals who meet the screening criteria to form a group. In this model, groups operate for up to 2 years and usually need 8–10 individuals and their family members committed to engaging in this group model. Preparing to market this group intervention will require informing not just individuals in your system who are living with schizophrenia but also their family members and significant support members. The workload of the group work leaders will need to be modified in order to provide them with time to engage potential individuals living with schizophrenia and their family/support members in joining sessions. Joining sessions is a key element of this evidence-based model.

Selecting and Applying Change Strategies

The core change strategies employed in the MFG model include building social networks and support, engaging in problem-solving sessions, and providing opportunities for both the individuals living with schizophrenia and their family/support members to improve communication and enhance relationship-building skills. Group leaders in this model need to be sure that the group structure is followed in each session in order to ensure that these core change strategies are achieved. Group leaders partner with group members and facilitate the key step of identifying a problem for group problem solving in each session once the group go-rounds are completed.

Assessing the Effectiveness of the Group Intervention

The MFG model can be evaluated using standardized measures that address individual functioning, problem-solving skills, social support networks, and relationship skills. These measures can be part of the baseline information gathered during the joining sessions and repeated every 6 months to assess changes in hoped-for outcomes. In addition, the fidelity measures and periodic satisfaction measures can provide needed information about the delivery of the model and the engagement of the participants over time.

This process of assessing the group will allow the EBGW practitioner to inform the team about what is working with this model and areas for improvement or change or adaptation to better meet the needs of your target population.

COGNITIVE-BEHAVIORAL GROUPS FOR CHILDREN AND ADOLESCENTS

Case Example

You are a clinical social worker who has been working with children and adolescents in an outpatient mental health setting. You also do outreach in the local schools. You have found that in your practice you often are working individually with youth teaching core cognitive behavioral strategies and that many of the youth would benefit from talking with others about what it is like living with a mental illness. Most of the youth you work with are isolated and have few social contacts outside of the school or formal settings. The youth come from lower socioeconomic communities, are racially and ethnically diverse (with most identifying as African American, Caucasian, or Latino), are between 12 and 14 years of age, and have diagnoses of anxiety and/or depression. A majority of the youth live with biological parents but some are in foster homes. You are interested in exploring starting a group at the outpatient mental health setting for this target population. You are aware that cognitive-behavioral approaches have been used effectively in groups.

Effective Planning

Because you are already a trained cognitive-behavioral therapist and have group work skills, your planning begins by exploring what research on group work with cognitive behavioral approaches has been conducted with youth similar to your target population. You discover that cognitive-behavioral group therapy originated from the work of Aaron Beck in the 1960s and is based on the concept that thoughts, feelings, and actions are all connected and influence each other (Whitfield, 2010). The target populations for child and adolescent cognitive-behavioral groups are individuals experiencing generalized anxiety disorder, social phobia, panic disorder, posttraumatic stress disorder (for those with similar traumas), mild obsessive-compulsive disorder, depression, and adolescent substance abuse (Whitfield, 2010). Cognitive-behavioral groups are also helpful for children and adolescents experiencing difficulty with anger management and handling stress and for social skills groups (Whitfield, 2010).

You recognize that your target population may be a good fit for this approach. You also review specific examples of EBGW cognitive-behavioral therapy (CBT) models, highlighted in Table 13.1.

You become aware that even though CBT groups address a range of problem areas, the formats of the groups tend to be structured and to provide opportunities for youth to demonstrate new skills and strategies for coping with their illness. When starting a CBT group, usually the group work leader provides an orientation to the group by explaining the purpose of the group and setting expectations such as goal setting, attendance, and time frames (Whitfield, 2010). This is typically when group cohesion is developed, as members are forming connections with others in the group, including the group work leader (Whitfield, 2010). In some groups, a motivational enhancement phase is implemented to assess readiness for change, which requires motivational interviewing techniques such as normalizing ambivalence and assessing for barriers (Whitfield, 2010).

TABLE 13.1. Examples of EBGW CBT Groups

Program	Target population	Session	Themes
Coping Cat (Kendall & Hedke, 2006)	Ages 7–13, experiencing anxiety disorders	16 weekly sessions, 50-minute sessions	Psychoeducation, exposure tasks, somatic management, relaxation, problem solving, parent involvement
C.A.T. Project (Kendall, Choudhury, Hudson, & Wolf, 2002)	Ages 14–17, experiencing anxiety disorders	16 weekly sessions, 50-minute sessions	Psychoeducation, exposure, skills for managing anxiety, problem solving
Cognitive-Behavioral Intervention for Trauma in Schools (Stein et al., 2003)	Ages 8–15, experiencing PTSD, typically surrounding community violence, or depression	10 weekly sessions, 60 minutes	Build skills to promote resilience, reduce trauma symptoms, provide peer support, parental involvement
Coping Power (Lochman, Wells, & Lenhart, 2008)	Ages 8–14 experiencing aggression	34 weekly sessions	Anger management, social problem solving, practicing skills to resist peer pressure and parental involvement

Cognitive-behavioral group interventions typically include a psychoeducational component. In addition to being in a group format, psychoeducation also helps normalize experiences and worries that group members may have about their thoughts, actions, or emotions (Whitfield, 2010). Psychoeducation can include information about how the brain affects the body, as well as statistics and facts about the group's identified goal.

These groups also include cognitive techniques such as pinpointing distorted thoughts and beliefs, cognitive restructuring, and managing physiological responses to anxiety (Starrenburg, Kuijpers, Hutschemaekers, & Engels, 2013). It is important that the group work leader first help the group members recognize their thoughts when they are feeling a certain emotion (Kendall, Choudhury, Hudson, & Wolf, 2000). Therapists can aid this process by helping group members keep a thought log and recording their thoughts when they encounter the specific issue the group is working on. Once they record their thoughts, the group work leader can introduce cognitive distortions, such as black-and-white thinking, magnification, mind reading, future telling, and emotional reasoning. Role play, behavioral activation strategies, and other opportunities to demonstrate greater understanding of the cognitive triad (thoughts, feelings, and behaviors) may follow.

In addition, CBT groups also include other behavioral components such as relaxation training, exposure based on the identified problem, and problem-solving skills (Starrenburg et al., 2013). It is important that the group members learn to become aware of their physical reactions associated with their feelings. For example, if the group is focusing on anxiety, it will be important that the members understand what their bodies feel like when they are worried. This may include sweaty palms, racing heart, tense muscles, and somatic complaints such as a headache or a stomachache. Once this skill is mastered, this awareness can serve as a cue to use relaxation techniques (Kendall et al., 2000). Relaxation techniques can include deep breathing, progressive muscle relaxation, positive imagery, and grounding. Exposure is important to help each group member experience the identified goal and use his

or her skills to manage his or her thoughts, actions, and emotions. Exposure first happens in-session and then occurs outside of the session (Kendall et al., 2000). Problem-solving skills are helpful in a group format because members can learn from all of the ideas and hear differing perspectives.

At the end of each cognitive-behavioral group session, the group worker may assign tasks to be completed outside of the session to help the members test out their new skills. Examples of typical cognitive-behavioral group assignments include practicing relaxation skills, journaling or using a thought log, and completing an exposure assignment. It is important that these tasks are relevant to each session and that the therapist checks in on each member's assignment from the previous session at the beginning of each new session. Rewards are predetermined and are given to members to help support their effort and their successes (Kendall et al., 2000).

With this new information about how to use cognitive-behavioral approaches in groups and the knowledge that these interventions are effective for youth from different racial and ethnic backgrounds, you decide to move to the next step.

Organizing and Forming the Group

You have selected the Coping Cat cognitive-behavioral group work model for your practice with the target population. You have a time that works in the early evenings for this group to occur, your supervisor supports you in developing and implementing this group, your supervisor has been successful at implementing cognitive-behavioral groups in the past and will be able to coach you during this process, you have secured the Coping Cat manuals and fidelity forms, and your agency is able to bill for the group session. You develop flyers to post at the agency waiting areas and do outreach in the schools and with other therapists to let them know that this group will be starting. You also have developed a screening tool to ensure that the youth who enter the group meet the core criteria that you established based on the research. Having the group at the agency will decrease stigma experienced by the youth if they attended a group during the school day, but it also raises transportation challenges. You have secured funding to provide transportation support to parents/caregivers in order to minimize obstacles to attending the group.

Selecting and Applying Change Strategies

Overall, cognitive-behavioral groups tend to feature several group processes that the group worker needs to attend to and be aware of during a group session, including optimism, inclusion, group learning, shifting self-focus, modification of maladaptive relational patterns, group cohesiveness, and emotional processing in the group setting (Burlingame & McClendon, 2008). You will examine with your supervisor the core process issues that emerge from the group sessions and also balance your process focus with the goals for each group session.

Assessing the Effectiveness of the Group Intervention

Several studies support the effectiveness of cognitive-behavioral group therapy for children and adolescents. Stice, Rohde, Seeley, and Gau (2008) found that a cognitive-behavioral group focused on depression in the school setting reduced symptoms significantly compared with the control group, which learned cognitive-behavioral techniques through self-help

literature. This supports the idea that group therapy helps provide members a sense of camaraderie and that they are able to better learn and understand the skills when discussed in a group setting. Flannery-Schroeder and Kendall (2000) found that 50% of the children ages 8–14 who experienced cognitive-behavioral group therapy did not meet criteria for anxiety after the treatment. One study regarding anger management with fourth- and fifth-grade boys revealed a significant reduction in symptoms by the end of the cognitive-behavioral group therapy (Sukhodolsky, Solomon, & Perine, 2000). These studies help promote the efficacy of cognitive-behavioral groups for children with a range of mental health disorders. In addition, to being effective, this type of group therapy is also cost-effective and can affect more children and adolescents at the same time (Whitfield, 2010).

You will include some of the outcome measures that have been used in the assessment of the Coping Cat program, and you also decide to incorporate periodic session feedback sheets to find out how the process elements are working for the participants.

PARENT MANAGEMENT TRAINING GROUPS

Case Example

Your community-based agency has been providing parent groups for parents/caregivers of children who have been diagnosed with attention-deficit and hyperactivity disorders (ages 3–10 years). The groups are offered in the evenings and run for 12 weeks. The group leaders have combined different resources to deliver the parent training components. The structure of the groups varies depending on who is leading the sessions. A majority of the parents are single parents and have more than one child in the home. Most of the parents work at low-paying jobs during the day while their children are in school. The parenting groups reflect the diversity of the community, which is primarily Caucasian with about one-third African American families. The leadership team at the agency is concerned that so many of the parents who are referred to the groups drop out after two sessions. You are tasked to explore other parent group models that may have a greater degree of success with your target population group.

Effective Planning

You begin your work by exploring the research that has been done on parent management groups. You find that several EBGW approaches that involve parent management and support groups have emerged over the past decades. Helping parents and caregivers of children and adolescents who are living with mental illnesses cope with caring for their children and providing them with needed strategies and techniques through EBGW approaches has been emerging as a core approach to intervention with this population. The idea of parent training originated in the 1960s and was based on the behavioral concepts of operant conditioning and applied behavioral analysis. These concepts stressed the importance of parents' and caregivers' positively reinforcing good behavior, or prosocial behavior, and negatively reinforcing negative behavior, or antisocial behavior, in children and adolescents (Forgatch, Patterson, & DeGarmo, 2005). Parent management practices may vary based on ethnic and cultural belief systems, and these initial models have been expanded to be more culturally responsive to a range of racial, ethnic, and culturally diverse participants (Leathers, Spielfogel, McMeel, & Atkins, 2011).

It is well known that parents experience a significant amount of stress when raising a child, especially when their child is living with a mental health disorder (Wu et al., 1999). Because parents and caregivers are crucial to the child's mental health treatment, it is

important that they receive their own support and intervention. Based on a review of studies of family-based and parenting groups, Hoagwood (2005) found that most group parent management interventions serve to help parents (1) identify their own parenting needs and concerns as they relate to their own child, (2) receive emotional and social support from other parents and caregivers who are experiencing similar struggles, and (3) learn new ways to manage their child or adolescent's difficult behaviors. Overall, Hoagwood (2005) reported that these groups reduce caregivers' sense of isolation, self-blame, and stress and increase their sense of empowerment.

Research on group parent management interventions supports these approaches as efficacious in treating parents and caregivers who have children and adolescents experiencing ADHD, disruptive behavior disorders, oppositional defiant disorder, conduct disorder, and juvenile-onset bipolar disorder. They have also proven to be helpful for parents who are struggling raising their children for various reasons, including having parenting styles that tend to be generally negative or ineffective, such as being power assertive, or having inconsistent consequences and rules (Pfiffner & Haack, 2014). Other mental illnesses that are being examined as being treated by group parent management training include autism and Tourette syndrome (Bloch & Leckman, 2009). You are happy to note that there are approaches that have demonstrated positive outcomes for parents of youth living with ADHD.

In another review of studies that focused only on parent support groups for parents and caregivers raising a child with a serious mental illness, Hoagwood and colleagues (2009) evaluated the findings from over 50 programs. The review identified five core group processes that were shared across group programs. These components included (1) information sharing and education, (2) skill development, (3) emotional support, (4) support through concrete services, and (5) advocacy support. The majority of the programs evaluated were conducted in a clinical setting and were led by a clinician; some were led by parent peers in the community; and even fewer were led by a team of professionals and parent peers (Hoagwood et al., 2009).

Until recently, the majority of group parent management trainings have been led by professionals, but emerging research also supports positive outcomes for parent peer-led groups (Gyamfi et al., 2010). An advantage of parent peer-facilitated groups over professionally led groups is that group participants relate more easily to the parent-peer facilitator, as members appreciate that the parent-peer leaders have firsthand knowledge about accessing care, living with a challenging child, and navigating other health-care-related obstacles (Hoagwood et al., 2009). You note that at your agency, you are hiring more parent-peer support workers and that training these workers to cofacilitate the parent management groups with a professional leader might be a possibility.

When implementing a professional-led parent management group, it is important to focus on promoting the therapeutic alliance, supporting and encouraging the development of parenting skills, preventing and managing resistance to change using motivational interviewing techniques, modeling and role-playing different parenting skills, problem-solving obstacles related to the group's preestablished goals, and eliciting information and solutions from parents rather than only directly teaching skills (Forgatch et al., 2005).

The EBGW parent management programs tend to use behavioral or cognitive-behavioral techniques as a primary approach to the group process. A majority of the EBGW group parent management programs use structured manuals for each session and have clearly identified goals and objectives. These programs include the Incredible Years Parent Training (IYPT), Positive Parenting Program (Triple-P), Defiant Children/Defiant Teens, and Keeping Foster and Kinship Parents Trained and Supported (KEEP) (Maliken & Katz, 2013). The KEEP program specializes in parent management training for African American

parents and foster care parents (Leathers et al., 2011). Table 13.2 highlights the key components of these programs. You decide after reviewing these programs that the Positive Parenting Program (Triple-P) might work best in your setting and with the target population of parents you serve (Leung, Sanders, Leung, Mak, & Lau, 2003; Markie-Dadds & Sanders, 2006; Sanders, Markie-Dadds, Tully, & Bor, 2000). The Triple P Positive Parenting Program is a comprehensive, multilevel prevention program that trains parents to use positive and nonviolent techniques when trying to manage their child's behavior. The program is designed to be administered at different levels depending on the severity of the issues that the child/youth is displaying.

The amount of sessions, the number of members, and the amount of time each session is held varies by program. Typically, parent management groups are held for 10–12 weekly sessions lasting about 90 minutes, with 12–15 group members. Although parent management groups only involve the parents or caregivers, the children typically receive outside mental health services as well (Barkley & Robin, 2014).

TABLE 13.2. Key EBGW Parent Management Training Models

Program	Target Group	Intervention approach	Sessions	Key themes
Defiant Children (Barkley, 2013)	Parents of children ages 2–12 with oppositional defiant disorder and/or ADHD	Behavioral	10 weekly sessions, 90 minutes	Improve parent management skills, increase knowledge about the cause of childhood defiant behavior, increase child compliance, reduce parental stress, positive attention, and consistent consequences
Defiant Teens (Barkley & Robin, 2014)	Parents with adolescents ages 13–18 years old with oppositional defiant disorder, ADHD, conduct disorder, and/or juvenile-onset bipolar disorder	Behavioral and cognitive	18 weekly sessions, 90 minutes	Improve parent management skills, knowledge about the cause of defiant behavior, increase teen cooperation, increase family harmony through positive attention and consistent consequences, increase problem-solving skills, address unreasonable beliefs
Incredible Years Parent Training (Webster-Stratton, 1990, 1994)	Parents with children ages 0–12 with ADHD, conduct disorder, and/or autism	Behavioral	12–20 weekly sessions for 2–3 hours	Strengthening parent-child interactions, improving relationships, reducing harsh discipline, increasing parents' ability to promote children's social, emotional, and language development
Positive Parent Program (Triple-P) (Leung et al., 2003; Markie-Dadds & Sanders, 2006; Sanders, Markie-Dadds, Tully, & Bor, 2000)	Parents with children ages 0–12 with difficult behaviors	Behavioral	Depends on the program, 1.5–2 hours	Safe engaging environment, positive learning environment, assertive discipline, realistic expectations, parental self-care

Organizing and Forming the Group

You survey potential members to find out the best times to offer the groups. You work to get the group leaders and parent-peer leaders trained and supervised to deliver the Triple P program. You address potential barriers to attendance with travel vouchers and child care supports. The support for the group leaders to prepare and review each group session is approved by the supervisors, and the workload requirements are adjusted as needed. You market the group at the school and at the community centers. The screening criteria for entrance into the group are established, and the decision has been made to keep this a closed group. Materials and manuals are in English and Spanish.

Applying Change Strategies

Group parent management interventions focus on improving parent–child interaction by addressing parenting in general, as well as parental attitudes and perceptions about their children’s behavior and their roles as parents (Kazdin, 2005). Themes include stressing the importance of immediacy, specificity, predictability, and consistency of consequences, using incentive techniques and positive reinforcement before resorting to punishment and negative reinforcement, anticipating and planning for misbehavior, and recognizing the idea that family interactions are reciprocal (Barkley & Robin, 2014). By focusing on consequences, parents learn how to increase the chances their child will cooperate with requests and rules. Incentive charts and positive reinforcement help promote positive behaviors and reduce inappropriate behavior by highlighting the appropriate behaviors they are doing rather than focusing on the negative behaviors. Negative reinforcement and discipline strategies are utilized when the positive reinforcement is not adequately reducing the inappropriate behaviors. Focusing on family interactions will help the parents understand how to make their encouragement more effective and realize that their responses will influence their children’s behavior. In addition, by focusing on family interactions, parents will reduce the likelihood of a power struggle with their children and adolescents (Barkley & Robin, 2014).

Assessing the Effectiveness of the Group Intervention

Through comprehensive studies of multiple behavioral and cognitive group-based parental programs, it was shown that group interventions are effective in improving children’s and adolescent’s behaviors, reducing parental anxiety, stress, and depression, increasing parenting skills, and improving the relationship between the parent and the child (Furlong et al., 2012). It has been found that compared with medication alone, group parent management, coupled with individual therapy for the child, was found to be more advantageous in coping with mental health symptoms (Kazdin, 2005). In addition to being effective, group parent management interventions are less expensive than the cost of potential long-term social, educational, and legal costs associated with childhood conduct problems and are more cost-effective than individual and family interventions (Furlong et al., 2012). Research on peer-led intervention groups has found that they enhance the members’ feelings of being connected with others, whereas clinician-led groups improve the members’ overall mental health (Toseland, Jones, & Parent, 2013).

Even though peer-led groups are increasing, there need to be more studies completed on the impact these groups have on both the parents’ and their children’s mental health. In addition, peer-led groups are not always billable, which may make them difficult to implement in the community (Hoagwood, 2005).

You review the outcome measures used to evaluate the Triple-P program and incorporate some of the measures in your evaluation of the group at your agency. You also add an engagement and barriers measure that is given after each group session to learn more about how best to facilitate attendance at the group sessions. You plan to bring the findings from this evaluation to the team and will adapt the interventions based on the lessons learned from this implementation effort.

THE CHALLENGES OF EBGW PRACTICE IN MENTAL HEALTH

As you will note from the three case illustrations, the process of forming and implementing an EBGW practice in mental health can be time-consuming and require significant resources to be successful in the implementation phase. In this section we highlight some of the key areas to consider when forming, implementing, and sustaining an EBGW practice.

First, recognize that the forming a group takes commitment, recruitment efforts can be time-consuming, and often workers or agencies have difficulty in getting individuals to agree to consider being in a group. Most individuals who have not participated in a group before may prefer to seek individual treatment or no services. Different cultural groups may find sharing problems or issues with others in a group a source of shame for themselves or their families. The stigma associated with having a mental illness or being a family member of someone living with a mental illness is also a barrier for many individuals who might benefit from participating in the group.

Second, group work leaders need to be trained in the EBGW practice, and this often involves a cost to the organization/program for training and ongoing supervision. If your agency or organization experiences high turnover rates, then investing in the EBGW practice may not be practical.

Sustaining the EBGW practice over time requires that the organizational supports stay in place and the evaluation of the groups demonstrate positive outcomes for the youth and adults who participate in the group interventions.

Although in the mental health field a number of groups occur across the prevention-to-recovery spectrum, most of these groups have not been evaluated and may not be producing the hoped-for outcomes for youth and adults seeking group services.

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CHAPTER 14

Involuntary Groups

RONALD ROONEY
MICHAEL CHOVANEC

In this chapter, we define involuntary groups, describe the purpose of social work with involuntary clients in groups, delineate appropriate interventions and their theoretical and empirical bases, and suggest guidelines for use of the interventions, with examples. We present an integration of individual and group stages of change and, finally, consider future directions, including incorporating more strength-oriented methods for such work.

DEFINITION OF GROUP SOCIAL WORK PRACTICE WITH INVOLUNTARY CLIENTS

Social workers often practice with involuntary clients in mandated groups and also in groups that are otherwise voluntary. Involuntary clients are persons who experience legal or nonlegal pressure to accept social services (Rooney, 2009). Some groups are composed of members who are either coerced or in other ways pressured to participate (Behrooz, 1992). *Mandated involuntary groups* are those in which coercion occurs through external, legal pressure (Rooney, 2009). For example, groups in corrections and with domestic violence perpetrators include legal mandates. In other cases, social workers encounter involuntary clients in otherwise voluntary groups. For example, some members may not freely choose to participate in a voluntary parenting group. The reason may be that they were referred by a child welfare worker who would monitor their participation as a factor in influencing a recommendation about child custody.

PURPOSE OF GROUP SOCIAL WORK PRACTICE WITH INVOLUNTARY CLIENTS

Social workers who practice with involuntary clients in groups perform dual roles of supporting social control and promoting individual growth potential. They perform a social

control purpose of community protection and client resocialization to roles that clients might not choose for themselves (Garvin, 1981). The profession has an extensive history of work with clients who are involuntary without using that term to describe them (Konopka, 1950; Pray, 1945; Roberts & Brownell, 1999). In the past 10 years, more attention has been devoted to such clients, using the term *involuntary* (Ivanoff, Blythe, & Tripodi, 1994; Rooney, 2009; Trotter, 1999). Applications to social group work with involuntary clients in corrections have also been reported (Goodman, 1997; Goodman, Getzel, & Ford, 1996).

Social workers employ a variety of strategies to promote individual growth potential. One major strategy is the principle of mutual aid designed to enhance individual growth potential (Behroozi, 1992; Goodman, 1997). For example, in addition to working toward protecting society from further crime, it has been possible to work with offenders to develop voluntary goals such as pursuing educational and employment opportunities (Goodman, 1997; Goodman et al., 1996).

INTERVENTIONS AND THEIR THEORETICAL AND EMPIRICAL BASES

Seven sources of interventions and their theoretical and empirical bases are reviewed. First, reactance theory provides a conceptual and theoretical basis for understanding opposition to change and ways to reduce that opposition. Second, solution-focused brief treatment (SFBT) provides a framework for focusing on strengths and accountability for solutions (Lee, Uken, & Sebold, 2004.). Third, the Partners for Change Outcome Management Systems (PCOMS) approach includes ways to incorporate client feedback into improving group intervention. Fourth, the stages-of-change model provides a useful framework for assessing motivation for change among involuntary clients. Fifth, motivational interviewing adds specific intervention guidelines directed to particular stages of change. Sixth, we review stages of change in groups for involuntary clients. And finally, we review a series of techniques that are useful in enhancing participation by involuntary group members. Based on these interventions, a matrix for conceptualizing involuntary groups and involuntary clients in otherwise voluntary groups is presented.

Reactance Theory

Reactance theory provides a useful framework for understanding clients who perceive themselves as being coerced into treatment. The theory assumes that people have a variety of behaviors that they are free to exercise at any time. When some of those presumed free behaviors are threatened or eliminated, a person experiences *reactance*, or a motivational drive to restore those free behaviors (Brehm & Brehm, 1981). For example, the “free behavior” of not attending treatment is threatened or eliminated when a person is mandated to attend a treatment program. The theory suggests that persons who are feeling pressured or coerced will behave in a variety of predictable ways, such as expressing anger toward the group leader, passive group participation, or withdrawal from treatment. The Therapeutic Reactance Scale (TRS) measures level of reactance within individuals (Dowd, Milne, & Wise, 1991; Dowd & Wallbrown, 1993). The TRS, in combination with clinical indicators such as refusal to complete homework assignments or previous poor treatment response, can be used to assess levels of reactance early in treatment (Beutler & Berren, 1995; Beutler, Kim, Davidson, Karno, & Fisher, 1996; Groth-Marnat, 1997; Prochaska, Norcross, & DiClemente, 1994).

Reactance theory suggests a variety of strategies to either increase or decrease opposition to change. For example, efforts to reduce reactance can include providing choices or clarifying what is and is not mandated (Rooney, 2009). One might wish to increase reactance if a client appeared to be unaware of the consequences of critical decisions he or she might make. To increase reactance, one would emphasize the consequences of failure to follow through with mandated changes for the involuntary client's future freedoms. Providing emotional support and reflection are recommended for highly reactant clients. Structure through contracting or use of contingencies is recommended with low-reactant clients. Early attention to reactance allows practitioners to engage the client more quickly and to increase the chances for a more successful outcome. The benefits of reframing resistance as normal reactance have been described in work in child welfare (Mirick, 2012a, 2012b).

Solution-Focused Brief Treatment and Involuntary Groups

Solution-focused brief treatment (SFBT) is a time-limited approach to assisting clients in creating solutions rather than eliminating deficits (De Jong & Berg, 2001, 2013). The approach has been applied to work with individual involuntary clients through exploring for exceptions to problematic behavior and building solutions (De Jong & Berg, 2001, 2013).

SFBT has also been applied to work with clients related to domestic violence (Lee, Sebold, & Uken, 2003; Lee, Uken, & Sebold, 2007). Rather than focusing on confronting clients about their deficits, the approach has been used to challenge them to create safe solutions. Group leaders lead participants to identify successes, behaviors they are proud of or have been complimented on. Self-identified goals are then selected, and well-formed goals or plans for enacting the larger goal are developed. In a single-group, pregroup--posttest design, 90 court-ordered participants were tracked for 6 months beyond completion of the 8-week group. Over 90% of participants completed the group, and the recidivism rate was 16%. At follow-up, 55% of participants and their partners were available. Further studies including control or comparison groups would be useful. Still, the approach offers considerable promise for engaging involuntary clients in groups through their strengths and hopes rather than confronting them about their deficits.

Partners for Change Outcome Management System

The Partners for Change Outcome Management System (PCOMS) is a collection of client feedback tools that have been found to increase retention and improve outcomes in random controlled studies with individual mental health clients (Miller, Duncan, Brown, Sorrell, & Chalk, 2006), couples (Anker, Duncan, & Sparks, 2009; Reese, Toland & Slone, 2010) and more recently with involuntary groups (Schuman, Slone, Reese, & Duncan, 2014). The instruments are designed to be a simple and efficient way for group facilitators to gather clients' perceptions of their level of distress and goals for therapy and to assess the therapeutic alliance. The instruments are incorporated into the therapy process and are not seen as a separate activity. In the group setting using the Outcome Rating Scale (ORS), group members are asked to evaluate levels of distress in their lives, including their personal well-being, family and close relationships, work, school, or peer friendships, and an overall distress rating. The Group Session Review Scale (GSRS) examines the group members' relationships with the facilitator, how well the session focused on what they wanted to work on, the fit of the therapy approach, and the overall experience of the group session. The reliability and validity has been found to be good considering the simplicity of the instruments (Bringhurst,

Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Miller, Duncan, Brown, Sparks, & Claud, 2003). Schuman and colleagues (2014), in a random controlled study of soldiers referred to an Army outpatient substance abuse program, found PCOMS to significantly improve retention and treatment outcome. Participants ($N = 263$) were assigned to either a feedback group ($n = 137$) using the ORS or a treatment-as-usual group ($n = 126$). Participants using the ORS reported significantly more improvement. Group facilitators and commanders who made the referral reported a higher percentage of successful ratings, and participants attended significantly more group sessions. Given this was a sample of active service men and women referred by their commanding officers, the setting has many similarities to other involuntary groups.

Stages-of-Change Model

The stages-of-change model evolved from research examining how people overcome addictive behaviors such as smoking, drinking, and excessive weight loss (Norcross, Beutler, & Clarkin, 1998; Prochaska et al., 1995). A series of five stages are identified related to changing of addictive behavior. In the *precontemplation stage*, clients do not recognize problems, but others in their environment perceive them as having problems. In the *contemplation stage*, clients identify problems but are not yet ready to act on those problems. In the *preparation stage*, clients are ready to begin preliminary efforts toward change. Those preliminary efforts become consistent in the *action stage*. Finally, in the *maintenance stage*, clients attempt to maintain changed behaviors.

The stages-of-change model has been applied to both chemical dependency groups (Hodgins, 2001; Yu & Watkins, 1996) and domestic abuse groups (Daniels & Murphy, 1997; Scott, 2004). The Stages-of-Change Scale (SOCS) has been developed for assessing client motivation (McConaughy, DiClemente, Prochaska, & Velicer, 1989). Efforts to use the SOCS to predict attrition in domestic abuse treatment has had mixed results. Bennett, Stoops, Flett, and Call (2005) found that probation ratings of men who were in the action stage of change were more likely to complete treatment. Scott (2004), using facilitator ratings of the SOCS, predicted treatment completion in 72% of his sample. However, in the same study, client ratings of the SOCS were not predictive of treatment completion. Similarly, Brodeur, Rondeau, Brochu, Lindsay, and Phelps (2008), using self-report questionnaires that included stage-of-change concepts, did not predict dropout and speculated that men's social desirability and program factors may be affecting the predictive power of the model. As the predictive power of the stage-of-change model continues to be examined, the clinical relevance of the model can still be useful for facilitators who work with involuntary groups. Chovanec (2009), in a study of 15 domestic abuse group facilitators, found most facilitators emphasizing work with precontemplators and paying close attention to the change process as men move through treatment.

MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI) suggests specific interventions designed to assist individuals in progressing along the stages of change. It was developed for work with clients with chemical dependency concerns, particularly those who were opposed to entering treatment (Miller & Rollnick, 2002). In this approach, however, resistance is reframed as ambivalence, and strategies are offered to address it. MI group facilitators are proactive in engaging

individual clients at any point on the continuum of motivation for change. In addition, client self-motivating statements toward change are identified and supported. For example, the group leader will take the lead in exploring ambivalence and eliciting self-motivating statements among clients in the precontemplation stage (Miller & Rollnick, 2002). This model has been used in combination with the stages-of-change model with work in groups of men who batter (Daniels & Murphy, 1997; Murphy & Baxter, 1997).

Studies have examined the efficacy of using MI with a variety of involuntary groups. McMurran (2009), in a systemic review of 19 studies, examined the application of MI to work with groups of offenders, including those in substance abuse ($n = 10$), domestic violence ($n = 3$), and drunk driving ($n = 5$). MI appears to be promising for increasing retention of offenders in substance abuse treatment (Carroll et al., 2006; Lincourt, Kuettel, & Bombardier, 2002; Sinha, Easton, Renee-Aubin, & Carroll, 2003) but less so with treatment for domestic violence (Kennerly, 1999). In improving motivation for change, it appears MI has had some success in both substance abuse treatment (Ginsburg, 2000; Sinha et al., 2003) and domestic abuse treatment (Easton, Swan, & Sinha, 2000; Kistenmacher, 2000). However, in using MI in creating behavior change with these client populations, there were mixed results in substance abuse treatment and no effect in treatment of domestic abuse (Kistenmacher, 2000). McMurran (2009) speculates that the complexity of the change process and the challenge of implementing the MI model in a clear and consistent fashion affect the results.

Stages of Group Change for Involuntary Groups

In addition to models of individual change in motivation over time, social workers have long found it useful to conceive of stages of change as applied to groups. Such stages were originally posed as applying relatively universally to most kinds of groups (Bennis & Shepard, 1956; Garland, Jones, & Kolodny, 1965). More recently, those stages have been adapted for specific populations, such as women (Schiller, 1995, 1997) and groups of older institutionalized persons (Berman-Rossi & Kelly, 1998). Unfortunately, the applications to date assume that all clients are voluntary, and hence they do not address the coercive forces that affect the group process for involuntary clients. In addition, a pregroup or preliminary stage of group development is not included in the aforementioned models. This stage is significant for involuntary groups, as potential group members make critical decisions about whether and how to engage in the group process prior to the first session. Most of the interventions articulated in this chapter focus on engaging the client and enhancing more voluntary participation in the group process. In this chapter, the Kurland and Salmon (1998) model of group development, which includes a preliminary stage, is integrated with the individual stage-of-change approach to help examine the change process for involuntary clients within the group setting and to suggest appropriate interventions.

Involuntary groups include a *pregroup planning phase*, in which potential leaders and organizations decide whether and how to form groups. Because involuntary groups are likely to stimulate reactance and to bring together persons many of whom are not eager to change, the first decision to be made is whether to form the group and, if so, how. Involuntary groups can provide an opportunity for in vivo learning in which members can learn from others, including peer modeling; can learn how to help others; and can provide a source of support for risk taking and making efforts to change. They can also be a source of effective confrontation or persuasion to stimulate dissonance (Rooney, 1992, p. 281). On the other hand, fellow members of involuntary groups can serve as role models for antisocial, as well

as prosocial, behavior, and some potential members do not learn well in groups and hence may make the experience less positive for others (Rooney, 1992, p. 284; Trotter, 1999). In this regard, it is useful to consider what kinds of choices are possible for group members and in what ways they can perceive personal benefit from group participation (Rooney, 2009).

Having decided to offer an involuntary group, the next step is pregroup contact (Kurland & Salmon, 1998). Potential group members are secured for the group and oriented to group participation. Such orientation includes discussing the voluntarism issue and eliciting the potential group member's thoughts and feelings about it. In this step with involuntary groups, leader efforts are made to enhance choices, however constrained, and to stimulate self-motivation for participation rather than relying exclusively on threats of punishment or promises of reward. Changes that are motivated by a perception that an individual will be benefitted, hence self-attributed, are more likely to be long-lasting than changes that occur as a result of either threats or rewards (Rooney, 1992). In this step, potential members are familiarized with rules, nonnegotiable policies, and choices available in the group. Such use of orientation for group members entering a program has been supported as a way of reducing group attrition in domestic violence programs (Brekke, 1989; Tolman & Bhosley, 1987).

In the *beginning stage* of group development, Kurland and Salmon (1998) indicate that members are anxious about the unknown, so themes of trust and distrust are prominent. Also, members present both approach and avoidance behaviors, as they want acceptance and want to change yet fear being hurt or made vulnerable. The major tasks in the beginning stage include orientation to the group, clarification of group purpose and norms, and finding commonalities between group members to build cohesion.

In the beginning stage of involuntary groups, members often do not detect a strong connection between their difficulties and those faced by others and hence have doubts about the likelihood of being helped by the group (Berman-Rossi & Kelly, 2000). Thus avoidance behaviors are more likely to be emphasized by group members. For example, in domestic abuse groups, men often present themselves in a wary, noncommittal fashion. Providing an opening statement that anticipates and addresses some of the initial concerns that men typically present is useful in reducing these avoidant behaviors and engaging men in the group process. In addition, it is important when clarifying norms that group leaders make explicit which norms are negotiable and which are not as a way of reducing reactance. Similar to those in voluntary groups, worker tasks at this stage include attempting to link individual motivations into a shared stake in the outcome of the group. In addition, group members often present themselves through anger and frustration early on in the development of involuntary groups. Reactance theory suggests that those who feel coerced into joining the group are more likely to express their frustration and anger toward the group leader. Group leaders are tested early and need to respond to the men's complaints in an empathic and respectful way without condoning their problem behaviors. Articulating group members' anger and frustration early on reduces opposition or avoids its being driven underground by threats of retribution. The group leader who responds to anger in a respectful way rather than cutting off or avoiding the issue models a way of dealing with anger without putting others down. For example, responding respectfully to anger in domestic abuse groups and not avoiding it provides an alternative to the use of anger for power and control that many of the men in the group have experienced.

In the *middle stage* of group development, Kurland and Salmon (1998) suggest that the group leader's role is less central, with support provided for increased leadership and mutual aid between group members. They suggest that group members are likely to be more comfortable with the group process and with examining their similarities to and differences

from other members. Members test the group leader to see to what extent they can express their feelings and bring problems to the group without being rejected or punished.

Depending on the extent to which conflict is identified and responded to in a respectful and empathic way, the middle stage is very similar to that in traditional or voluntary groups. Group leadership is tapped, and support is provided for the exchange of mutual aid between members. For example, veteran members can be encouraged to explain ground rules or assist in providing guidance for new members in completing required tasks. The group leader in involuntary groups continues to have a power to reward and punish that does not disappear. The leader can, however, specify that recommendations will not be made capriciously based on likes and dislikes but rather based on accomplishment of tasks. How well the initial anger and frustration that group members present is responded to determines whether the group becomes a safe place to support individual change or never reaches the level of cohesion and trust needed to fully experience this middle stage.

In the *ending* stage, Kurland and Salmon (1998) suggest that the group leader's role is to guide the differentiation process, assisting group members to articulate the changes they have made and supporting their efforts to reconnect with resources outside the group.

Similar to the middle stages of involuntary groups, the ending stages are strongly dependent on how well initial contacts with group members are made. If the initial anger and frustration is addressed directly and in a respectful way, endings appear similar to those in voluntary groups. A key factor is whether the group is closed or open-ended. In open-ended groups, the ending process is less intense, as members are leaving at different times. Also, there are typically completion requirements that determine when a group member finishes that add more structure to the ending process. In addition, the levels of changes made by individuals vary widely. Changes made by group members need to be articulated and validated by the group member, the leader, and others in the group.

Techniques for Engaging Involuntary Clients in the Group Process

Thomas and Caplan (1999) propose 56 useful techniques for enhancing participation of involuntary clients in groups and place those techniques into three major categories of enhancing *process*, *inclusion*, and *linking*. The group facilitator uses *process* interventions to identify the emotional message behind the client's statement and reflects the client's worldview. *Linking* interventions are used to connect clients' individual issues with those of others in the group and to allow the group leader to make generalized statements about the group itself. *Inclusion* interventions encourage uninvolved group members to join the group discussion and include didactic and projective exercises that allow group members to voice their opinions without being singled out.

Techniques for Examining Faulty Beliefs

How can group members be helped to address critical issues without feeling singled out and blamed? For example, in the corrections field, leaders who utilize a cognitive restructuring framework consider that some of the difficulties experienced by law violators emerge from faulty thinking patterns. Some group members, for instance, may believe that "money will solve all my problems." Such beliefs are not socially acceptable, and members might not readily attest to belief in them. Using the *sophistry* method, group members who have committed crimes are asked to debate the pros and cons of such beliefs without immediately acknowledging their own views about these beliefs. For example, some group members

would argue in favor of the position that “if I have been treated unfairly, I have a right to treat others unfairly,” whereas others would be asked to dispute that position (Evans & Kane, 1996, p. 114). Such examination can then engage members in assessing whether those beliefs may play a part in their legal difficulties.

Techniques for Appropriately Confronting Clients

More forceful addressing of critical issues occurs when members are confronted about harmful thoughts and behavior. Confrontational approaches were introduced into the chemical dependency field in the 1970s and 1980s (Thomas & Yoshioka, 1989). In the domestic abuse field, confrontation has been used to address men’s rationalizations about abusive behavior and as a way of discussing gender, power, and control issues (Pence & Paymar, 1993). Motivational change approaches based on the stages-of-change conception and reactance theory provide alternatives to these traditional confrontational approaches. Murphy and Baxter (1997) describe the negative consequences of using a highly confrontational approach with domestic abuse perpetrators that might increase their defensiveness and reinforce their belief that relationships are based on coercion. That is, if members believe that group leaders can impose their will and beliefs on abuse perpetrators because they possess the power to coerce, then their belief that power in a relationship is based on ability to coerce is not being challenged.

There is also evidence that highly confrontational approaches lead to poor client outcomes (Yalom & Lieberman, 1971) and that clients with low self-esteem and poor self-concepts are more likely to deteriorate within the group setting (Lambert & Bergin, 1994). A confrontation–denial cycle has been described as occurring in many groups, whereby intensive confrontations by leaders stimulate a round of denials by clients, setting off another wave of confrontations and denials (Murphy & Baxter, 1997). Interventions that do not insist that clients label themselves as deviant but rather focus on those actions that are likely to help them achieve their goals are less likely to provoke this confrontation–denial cycle (Murphy & Baxter, 1997). In this approach, the group leader attempts to understand the world from the client’s viewpoint and supports the client’s ownership of responsibility for change (Kear-Colwell & Pollock, 1997). Emphasis is placed on understanding pathways that have led to undesirable outcomes.

GUIDELINES AND EXAMPLES FOR SOCIAL WORKERS WITH INVOLUNTARY GROUPS THROUGHOUT STAGES OF DEVELOPMENT

Based on the preceding perspectives, the following seven guidelines are suggested for work with involuntary client groups and individuals in otherwise voluntary groups. As we present the guidelines for intervention, we integrate them with the expected stage of group development and individual motivation for change (see Table 14.1).

1. *Make an appropriate organizational decision about whether a group needs to be involuntary.* Because involuntary groups contain both opportunities and challenges, the first question to be answered is whether the group needs to be involuntary, and, if so, what are these requirements? Hence the first step is to identify those non-negotiable parts of the group’s mission from the organization. For example, patients on an inpatient psychiatric unit might be expected to participate in group treatment as determined in their treatment

TABLE 14.1. Interventions, Group Stages of Change, and Stages of Individual Development

Interventions	Stage of change	Anticipated level of individual development
1. Make organizational decision about use of involuntary group.	Pregroup planning	Precontemplation
2. Pregroup orientation. - Initial orientation of group. - Reframe from resistance to ambivalence. - Clarify choices.		
3. Emphasize joining and inclusion. - Clarify non-negotiables. - Support positive choices made to date. - Provide emotional support. - Identify self-motivating statements. - Provide opening statement addressing client initial concerns/fears. - Link to process. - Support inclusion. - Link members to each other. - Stimulate nonthreatening attention to issues. - Continue reframing resistance as ambivalence.	Beginning	Precontemplation
4. Decide to make a change. - Assist in assessing costs and benefits of change. - Provide information about choices.	Middle	Contemplation
5. Support in planning actions.		Action
6. Emphasize responsibility for choices rather than confrontation.		
7. Utilize clear criteria for group completion. Plan for maintenance; address relapse.	Ending	Maintenance

plans. Similarly, a group for domestic violence perpetrators must explore alternatives to violent resolution to disputes. The more freedoms that are threatened, the more likely it is that reactance will be stimulated. Hence, in addition to non-negotiable requirements, it is important to explore what portions of the purpose and methods of a group can either be negotiable or include choices to be made by members. Hence, if members of groups on psychiatric units can have some say in the topics to be discussed or some choice regarding which groups they participate in, reactance could be expected to be reduced. For example, men in a domestic violence program must complete at least 12 of 15 group sessions in order to graduate; they can, however, choose which sessions, if any, they will not attend. Choices can be increased for those potential members who complain about the length or cost of the program by providing the phone numbers of surrounding programs to increase their range of selection.

2. *Conduct pregroup orientation.* Pregroup orientation is useful for members of voluntary groups as well, but particular advantages accrue for involuntary groups. By assessing the potential client's current motivation on the cycle of change, the leader can present interventions that fit the motivation of members. Similarly, reactance may be reduced by clarifying expectations, including negotiable options and choices. These sessions can also raise the opportunity for contracting concerning other, more voluntary problems acknowledged by potential members, such as securing further education.

Similar guidelines can be followed to enhance voluntarism of members who experience pressure to participate in an otherwise voluntary group. For example, with the parent who is referred to a parenting group, the group leader can first identify and empathize with the pressure felt by the potential member. The leader can then clarify that the potential member can in fact choose *not* to be a member of this group and take the consequences from the referring worker or solicit a different referral. In this way, the leader can begin to emphasize choice in participating in the group. If the potential member then *chooses* to be a member, he or she can also decide to pursue personal goals, as well as to carry out the mandated participation. For example, he or she might choose to seek support for circumstances as a single parent and choose to focus on parenting supports and strategies for single parents.

3. *Emphasize methods to assist in joining and inclusion in early sessions.* Special efforts have to be made in involuntary groups to assist members to join the group in the *beginning phase* and feel included. The leader can assume that most members of an involuntary group are initially at the *precontemplation* stage of individual motivation for change, in which they do not now recognize a need for change. Interventions that engage members in taking in new information about the costs and benefits of behaviors without forcing them to accept those attitudes and beliefs are appropriate for this stage. This phase also contains explicit contracting that includes both required group goals and problems and those selected more voluntarily by individuals. Discussion of goals can be guided by the use of the ORS, on which clients assess their level of distress, and, through dialogue between facilitator and client, plans to reduce that stress are made. Also any incongruence between the client's story and level of stress reported can be discussed and resolved.

A prepared opening statement by the group facilitator can be an important part of an orientation session. This opening statement allows the facilitator to join with the potential group members by anticipating some of the major questions and concerns members are expected to bring with them as they enter a program. For example, the following is an opening statement one could use with men entering a domestic abuse program. Techniques utilized and their purposes are indicated in *italics*.

"Welcome to the program. I know many of you may feel as if you have been forced to come here. Many men who are in similar situations never make it this far to come to the first meeting. I support your choice in attending the program [*emphasizing choices already made*]. You may think that we will try to force you to change. The reality is that no one can make you change [*emphasizing choice to reduce reactance*]. All we ask is that you listen to what is said and take the bits and pieces of the program that make sense to you and that can help you avoid future problems and contact with the court system [*limited, clear requirements to reduce reactance*].

"You may also fear that you will be judged as guilty or shamed for the incident that brought you here. Many of you have already gone through the court system. We are not here to judge you as guilty or innocent for the charges you bring with you [*clarifying*

role and avoiding emphasis on blaming]. Our focus is on helping you to learn from whatever incident brings you in. Our task is to create a safe environment for men to examine their actions and learn from their mistakes [*positive, future-oriented focus*].

“The group has some rules. Physical or verbal abuse is not tolerated in our group sessions. If you cause it, you will be asked to leave the group session. What we say here is confidential and should not be shared outside the group [*clarifying non-negotiable requirements*]. I cannot force group members to do this but expect you will keep confidence in respect for others in the group. I have to break confidentiality if you tell me that you are in danger of hurting yourself or others, since legally I must report that information to other professionals or the authorities [*clarifying rights and limitations*].”

The preceding statement emphasizes choices and avoids blaming statements in an effort to reduce reactance. Non-negotiable rules are shared, as well as the rationale for them. After this introduction, members are asked to share information about the circumstances of their referral and the goals they are setting for themselves for group participation.

In the circumstance of the involuntary member in an otherwise voluntary group, efforts at this stage can similarly reinforce choices about participation and freedom to choose not to participate actively but to learn by observing persons who are further along in the change process. So, for example, the reluctant participant in the parenting group could choose to be an observer until he or she feels more comfortable about group participation.

4. *As group members progress into the contemplation phase, emphasis is placed on deciding to make a change.* While some members are progressing into the *contemplation* phase of individual motivation for change, the group as a whole may be in the middle phase. As noted, as many as a third or a quarter of involuntary clients may be at the *contemplation* phase of individual motivation at the beginning of the group. Leader efforts at this stage are focused on helping clients to examine the costs and benefits of change and to make a decision to change or not to change. Individual ambivalence is explored, and particular themes in each member’s struggle to change are identified and then linked to those of the other group members. This intervention provides an opportunity for all group members to contribute (inclusion) and builds group cohesion.

For example, a client in the domestic violence group, Jack, reports in the fourth session: “I have decided that I will not try to contact my ex-partner anymore. My ex-partner should have a group like this, but I know I did shove her. I am realizing that I was a jerk at times.

“Things just started building up and when she got in my face and told me she didn’t love me anymore I couldn’t handle it.”

LEADER: It takes a lot of courage to look at oneself and take responsibility [*rewarding acknowledging responsibility*]. What helped you do this? (*after hearing Jack’s response*) It sounds as if you wanted to make sure this type of incident doesn’t happen again. Certainly, staying sober is a good first step in figuring out what to do differently. How is not drinking working for you [*supporting and reinforcing choices*]?

After Jack responds to this question asking him about a choice and a strength, the leader turns to the group: “Has anyone else decided not to use alcohol or drugs as a result of the incident that brought them in to the program?” The leader reinforces Jack’s self-motivating statement about maintaining sobriety and tries to link Jack’s progress in staying

sober with the experiences of others in the group. In the process, other men may identify self-care strategies that might be useful for Jack.

JACK: I just decided it was time to quit using because I have had nothing but trouble when I start drinking. I am getting tired of it. Sure, I get urges to use every day, but I just think about being in jail and decide I'm not going there.

LEADER: So, Jack, you think about the consequences and make a decision that drinking is not working for you; it can be a trigger to violence. What kinds of triggers have the rest of you noticed that often come before a violent episode?

The leader is linking Jack's concerns with those of other group members, attempting to stimulate inclusion in the group as others relate to precipitants toward violence. The leader expresses empathy, articulates the ambivalence, and focuses on the positive side toward change. He identifies what the client takes responsibility for, supports positive changes already made, and draws on other members for support.

5. *Members are assisted in the action phase to plan specific actions to address the problem.* Examining alternatives is most relevant in the action phase of individual motivation for change. For example, men in groups for domestic violence perpetrators often have to complete a role-play task demonstrating that they have a plan for dealing with a potential conflict with someone in their current lives. In this potential future encounter, they are asked to identify the various cues they anticipate in interactions with this person and how they will address anger and keep themselves calm during the exchange.

In the parenting group, the initially reluctant member, along with other participants, would be asked to make a plan based on skills learned so far for addressing a potential parenting conflict that they are concerned about. For example, the reluctant member might be concerned with getting her child to go to bed on time. This issue may or may not be considered significant by the referring worker, but it is a voluntary issue to the parent. By emphasizing choice about what situation to select and which strategies to employ, the leader can emphasize self-attribution and support choices.

6. *Emphasis on reporting successes and exploring exceptions.* Incorporating aspects of SFBT, the leader can encourage members to begin reports of their efforts between sessions with successful efforts rather than beginning with failures (Lee et al., 2004). Even when efforts have not been fully successful, the leader can lead members to identify those parts of the effort that did succeed. For example, if a member reports that his efforts to take a time-out when angry were not fully successful, the leader, after hearing details of the effort, might help the member explore what was different when he was able to take a time-out and to plan for more successful use of the technique.

7. *Emphasis on taking responsibility for choices rather than confrontation.* If the leader emphasizes taking responsibility for choices, reactance should be reduced, and influence efforts can be focused productively around areas of motivation. For example, Roger, another member of the domestic violence group, reports the following in a middle session: "My wife and kids won't talk to me. I call them and they hang up. She's got this restraining order so I can't even talk to her and the kids. That's not right. I should be able to talk to my own family. I am tired of all this. I am going to go over there and handle it."

When the leader clarifies that by handling it, Roger means going over to his wife's home and talking to her, thereby violating the restraining order, he turns to others in the group to

ask: “What do you think of Roger’s plan? Do you think that is going to help him get out of this group successfully and get back with his wife and kids [*articulating Roger’s personal goals for the program*]?” Group members point out to Roger that this is the kind of decision that got him into the group in the first place and that his situation will only get worse. The leader points out to Roger that, if he chooses to violate the restraining order and potentially endanger his wife, the leader will have to warn her, and Roger will not be able to continue in the group. This fact is presented not as a humiliating confrontation but as a statement of consequences. He then goes on to ask Roger and other group members: “Can you think of other ways Roger might be able to initiate contact with his wife and kids without violating the restraining order or acting against their will [*alternative means to reach the same goal*]?” This move to problem solving leads the group to recommend that Roger write a letter to his wife and children telling them how much he cares for them and how he is working in the group to get control of his anger.

8. *Utilize clear criteria for group completion.* Reactance is likely to be reduced by having clear behavioral goals rather than vague, amorphous ones. Consequently, if the criteria for group completion clearly spell out what a member is to do, reactance should be reduced. For example, in the domestic violence group, a commitment to carrying out specific tasks designed to implement nonviolent solutions is easy to assess regarding group completion. The group for domestic violence perpetrators contains the requirement of attending 15 group sessions and completing eight tasks. A tracking sheet is shared with men in orientation that identifies the topics covered over the 15 weeks and lists the tasks they are required to complete. This tracking sheet is then given to the probation officer once the men have completed the program, with program participation measured by sessions attended and tasks completed. Expectations and instructions for completing each task are available for review before they begin to work on them.

Similarly, in the parenting group, all group members—but especially those who are initially reluctant—will benefit from a clear delineation of the expectations for successful completion of the group. For example, each member is expected to attend regularly, to listen to presentations on different topics, and to choose an area most applicable to him or her in which to focus planning for improvement. Focusing attention on a self-selected area, such as interaction around bedtime, is likely to increase voluntarism.

SUMMARY AND CONCLUSIONS

We have explored how social workers can perform dual roles in work with involuntary clients in groups pursuing social control and fostering individual growth. This dual pursuit suggests two areas for continued development: the systems context for work with involuntary clients and evaluation of intervention.

The Systems Context for Work with Involuntary Clients

Social workers operate within a systems perspective that examines the conditions under which illegal behavior or behavior labeled as deviant occurs. In this regard, social workers are mindful of overrepresentation of members of oppressed groups and persons of color among involuntary clients (Diorio, 1992; Horejsi, Heavy Runner Craig, & Pablo, 1992; Longres, 1991; Rooney & Bibus, 1995). Hence social workers are aware of overrepresentation of

persons of color among more restrictive treatments across many populations and problems. For example, persons of color are more likely to be in prison and to receive more restrictive options for mental health problems and are more likely to have their children in out-of-home care (Dewberry Rooney, 2001; Morton, 2001).

Social workers note that restricted access to resources, as well as living in unsafe neighborhoods with inadequate schools, plays a part in determining which members of society are likely to become involuntary clients. Many treatment approaches for work with offenders emphasize examination of personal choices and taking responsibility for behavior. Social workers support that emphasis to a degree. Looking at individual pathways that have led into particular choices and behavior can be constructive. Instead of ineffectual or harmful raging against persons and systems considered unfair, the group can be an arena for learning safe, effective methods of negotiating systems. Anger can be channeled into empowering, rather than abusive, actions. Clients such as Roger can be taught to work with an attorney to ensure regular, consistent, safe visitations with their children rather than threatening their spouses.

Social workers employ an empowering perspective to look beyond individual pathways and examine group pathways and access to resources. Hence social workers examine those social conditions that made that involuntary contact more likely. For example, Roger may link with others in the group who are having difficulty making contact with their children and develop strategies for working with probation and law enforcement to increase opportunities to demonstrate the changes they are making and improve access to their children. Similarly, an empowerment perspective would suggest exploring messages about violence in the media and providing opportunities to learn alternatives to violence in schools. An empowerment perspective also suggests exploring organizational factors and attitudes that contribute to disproportionate racial representation among clients in fields such as child welfare (Dewberry Rooney, 2001).

The Importance of Evaluation

Much of the work with involuntary clients in groups appears untested and/or ineffective. In the area of domestic violence, between 40 and 60% of the men who enter a treatment program have been reported to drop out within the first three sessions (Gondolf, 1997), with one study examining the attrition rate from inquiry to treatment completion and finding that less than 1% completed the 8-month program (Gondolf & Foster, 1991). Failure to complete a treatment program can have a significant impact on men's partners, as well. Gondolf (1988) found that when men reported to their partners that they were attending treatment, those partners were more likely to return to them. Hence high attrition rates in domestic abuse treatment put women at risk for future abuse.

In addition, group leaders of involuntary groups are in explicit positions of power, influencing program participants and determining who graduates. Many involuntary clients have experience with authority figures who have used abusive power over them. Ongoing group evaluation that assesses program interventions and outcomes helps ensure that programs do not replicate the abusive background that many clients entering involuntary groups have experienced.

Evaluation of involuntary groups needs to address the achievement of both social control and individual growth goals. That is, evaluation needs to address whether, for instance, violence is reduced and whether repeated offenses decline. But evaluation should also

explore whether members set and reach personal growth goals. Process studies are needed that show whether members learn new skills and whether engagement methods such as those described in this chapter enhance attendance and group completion. In addition to evaluations that emphasize the reduction of deficits, those that incorporate the assessment of competencies and strengths should be increased (Lee et al., 2007).

Finally, social workers who lead involuntary groups have an ethical responsibility to evaluate their practice and base their interventions on best practices, such as those suggested herein. If social workers are to achieve success in pursuing both social control and individual growth with members of involuntary groups, they will need to employ effective skills in engaging participants in the group process and to evaluate the success of those methods and groups. Only through this regular examination of the involuntary process found in a variety of groups will clients, their families, and the community be better served.

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CHAPTER 15

Strengths-Based Group Work with Children and Adolescents

ANDREW MALEKOFF

This chapter introduces a framework for strengths-based group work practice with children and adolescents. At the heart of the presentation are seven practice principles that are described and illustrated:

1. Form groups based on members' felt needs and wants, not diagnoses.
2. Structure groups to welcome the whole person, not just the troubled parts.
3. Integrate verbal and nonverbal activities.
4. Decentralize authority and turn control over to group members.
5. Develop alliances with relevant other people in group members' lives.
6. Maintain a dual focus on individual change and social reform.
7. Understand and respect group development as a key to promoting change.

The settings in which the illustrations take place include an outpatient mental health clinic, a community center, public schools, an organic farm, and a school-based mental health/day treatment facility. The strengths-based practice described has universal application across settings and populations served.

STRENGTHS-BASED SOCIAL WORK: TAPPING IN TO WHAT ONE HAS TO OFFER

The practice of drawing on what people have to offer is another way of saying that strengths matter. Helping people to discover the resources to improve their situations is not an option for social workers but an obligation. It is our duty to understand what people know, what they can do, and what they and their environments have to offer. To do this, we must be willing to look beyond labels, categories, and diagnoses. We need to assume a position of

uncertainty, a commitment to developing relationships with children, adolescents, and parents that transcends the traditional paradigm of practitioner as knowledgeable expert and client as naïve initiate, relationships that capture the joy of human collaboration. Establishing a strengths perspective is a good starting point.

RESEARCH ON STRENGTHS-BASED PRACTICE

The effectiveness of the strengths-based framework presented herein has not been formally evaluated. Instead, I present literature on core influences on this framework: strengths-based social work and youth development.

Some of the “converging lines of research and practice” that support the strengths perspective are in the areas of developmental resilience, health and wellness, story and narrative, and solution-focused approaches (Saleebey, 1996, 2001, 2002).

Developmental resilience studies provide a valuable perspective on the growth-enhancing impact of protective factors and the strength-based variables that mitigate against risk. Extensive studies (Rutter, 1995; Werner, 2000; Werner & Smith, 2001; Werner, Smith, & Garmezy, 1998) found that stimulating and supportive environments are a significant counterforce to constitutional vulnerabilities in children and youth. There are young people who, despite an exposure to multiple risk factors, do not succumb to serious health and behavior problems (e.g., substance abuse, violence, teen pregnancy, school dropout, and delinquency). In the assessment arena, a series of measures and protocols have been designed to help practitioners recognize and work with strengths in children and families (Early, 2001; Gilgun, 1999; Gilgun, Keskinen, Marti, & Jones, 1999; Graybeal, 2001).

An important arena for strengths-based research is in the youth development field (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 1998; Onserud, 2012; Onserud, Stein Brockway, & Mancell, 2009). At the core of youth development research is the identification of personal and social assets (i.e., strengths) that facilitate positive youth development (Benson, 1997; Eccles & Gootman, 2002).

STRENGTHS-BASED BUILDING BLOCKS

The Search Institute developed a framework of assets that are signposts of positive child and adolescent development. A review of more than 800 studies provided a scientific foundation for the 40 developmental assets identified by the Search Institute (Scales & Leffert, 1999). For a complete list of assets, refer to www.search-institute.org/content/40-developmental-assets-adolescents-ages-12-18.

As both a theoretical and research framework, the assets are divided into external (e.g., factors in the environment that promote health and strengths) and internal (e.g., factors in the individual, such as competencies and prosocial values, that represent strengths). Following are examples of skills that group participation in youth development programs aim to develop in young people (Onserud, Stein Brockway, & Mancell, 2009, p. 8):

- The ability to be a member of a team, to work well with others, to complete projects together, and to develop the capacity for mutual aid.
- The ability to work constructively on conflicts and relationships, including giving and receiving feedback.

- The ability to think critically about one's own ideas, to develop an appreciation for different perspectives and opinions, and to integrate other points of view.
- The capacity to share leadership with the group leader and other members and to take increasing responsibility for the group process through shared decision making and problem solving.
- The ability to see oneself and the group as part of a larger, multigenerational community that values the contributions of participants of all ages and strives to have a positive impact on the lives of children and families.

Group work and youth development are not new (Onserud, 2012). Both have existed since the early part of the 20th century. In fact, group work was the bedrock of early youth development, and group workers were the driving force in community centers, neighborhood clubs, and camps and on playgrounds and street corners (Malekoff, 1998, 2002). The Search Institute's 40 developmental assets could easily be renamed *40 strengths-based building blocks*. The assets have relevance to group workers working with children and adolescents from a strengths-based perspective. They offer group workers some direction for identifying needs and setting group goals, establishing alliances with parents and relevant other people, stimulating creative activities, and developing leadership skills.

COGNITIVE-BEHAVIORAL APPROACHES, STRENGTHS-BASED GROUP WORK, AND BEYOND

A leading proponent of the sociobehavioral approach in the field of group work with children and youth was the late Sheldon Rose. He developed the cognitive-behavioral interactional approach of group therapy (Rose, 1998). In this model, the small group is the context for social reinforcement of prosocial behavior, a concept most significant for group work with children and adolescents. As the child begins to step beyond the family unit in adolescence, he or she forms a growing attachment to the peer group. Included among the various behavioral methods of teaching coping skills to children and adolescents are problem solving and sociorecreational methods.

In changing times, different theoretical approaches gain favor as an accommodation to the social, political, and economic realities of the day. Group workers who decide to adapt various approaches can integrate them with the strengths-based principles described herein. For example, using a cognitive-behavioral approach in group work with adolescents does not preclude fostering mutual aid, using the group to promote competence and autonomy, actively engaging parents, or understanding the role of group process as a powerful change dynamic. The challenge for group workers subscribing to strengths-based principles is to create avenues for integration across disciplines and models.

A FRAMEWORK FOR STRENGTHS-BASED GROUP WORK WITH CHILDREN AND ADOLESCENTS

The following seven-principle framework for strengths-based group work with children and adolescents evolved from my group work practice experience over the past four decades (Malekoff, 2001, 2011, 2014). Readers should take special note of Saleebey's (2002) principles of the strengths perspective:

Every individual, group, family, and community has its strengths; trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity; assume that you do not know the upper limits of the capacity to grow and change and take individual, group, and community aspirations seriously; we best serve clients by collaborating with them; every environment is full of resources; and caring, care taking, and context count. (pp. 13–18)

The seven principles are described as follows and illustrated to bring to life their practical application. The illustrations are a combination of practice summaries, brief vignettes, and longer narratives. Readers should note that, although examples are chosen to illustrate specific principles, the principles are overlapping and interrelated.

Principle 1: Form Groups Based on Members' Felt Needs and Wants, Not Diagnoses

Groups must not be formed on the basis of a diagnosis or a label. Groups should be formed on the basis of felt needs and wants. Felt needs are different from ascribed labels. Understanding members' felt needs is where we begin in group work. This is such a simple concept, yet so foreign to so many.

Failed groups may be blamed on unmotivated and resistant children and adolescents or uncooperative and sabotaging parents when, all too often, the real culprit is poor planning. Beyond identifying need, good group work practice with children and adolescents requires a planning process that includes gaining sanction and support from agency administration, developing a clear purpose, selecting and screening members carefully, attending to the structural details (i.e., time and space) of the effort, and identifying appropriate content and materials for the group to meet its goals (Malekoff, 2014, pp. 69–97). Nevertheless, we begin with need.

Felt needs refers to individual wants, desires, and areas of concern that are both *unique* to individuals in the target population and *universal* to individuals in the target population (e.g., normative adolescent issues, developmental tasks, the need to negotiate difficult environments).

A group for juvenile offenders is offered as an illustration of blending unique and universal needs. The group was formed around the activity of boxing (Wright, 2002). The purposes of the group—to learn the art and science of boxing, to prevent violence, and to enhance personal and social growth—represent the two levels of felt need. Learning the skill of boxing represents a unique need, a desire of the boys who were recruited for this particular group. In today's world, violence prevention could be viewed as a universal need or, for this group, a unique need, given their juvenile offender status and the dangerous context of their lives. The need to enhance personal and social growth is universal. Learning boxing helps the group members to reach several physical goals (e.g., boxing, rope skipping, calisthenics). It also helps them to address social and personal growth in the areas of identity, defense, impulse control, patience, focus, commitment, respect (for self, others, and referee), stress relief, and peer support.

Understanding felt needs is a prerequisite to establishing group purpose, deciding on group composition, setting individual and group goals and objectives, and determining what content or means a children's or adolescents' group will use to reach its ends. Knowledge and use of the often-neglected planning process is a prerequisite for workers with all sound groups.

Principle 2: Structure Groups to Welcome the Whole Person, Not Just the Troubled Parts

Group workers must learn to structure groups to welcome the whole person and not just the troubled, hurt, or broken parts. There is so much talk these days about strengths and wellness. This is hardly a new and revolutionary concept. But it has been neglected for too long.

A children's group is a great place for young people to come face-to-face with various levels of difference, to confront the impulse to isolate and objectify the unfamiliar, and to reach for strength amid diversity.

In an early meeting of the "changing-family group" in a child guidance center, the themes of difference and inclusion came to the fore. Each of the seven 9- and 10-year-old group members had experienced upheaval in his or her family. The parents had divorced, separated, or died. The purpose of the group was to reduce isolation, to explore feelings of loss, and to help members learn how to cope with these changes.

Near the end of the third meeting of the group, the group worker gave a homework assignment: "Over the next week think of something that is important to you, something that you really value, and bring it in to the next group meeting to share with the group." Allie, a 9-year-old whose father had died just months before, said, "I know what I'd like to bring . . . but I'd have to dig him up." Time seemed to stand still as the group worker silently awaited a response from the group.

Suddenly and unexpectedly, Jimmy, who had been labeled as "hyperactive" and was by then all over the room and into the toys and games on the shelves, stopped what he was doing. He bounded over to Allie and got about as physically close to her as he could without making physical contact. Without asking her what she had meant by her statement, Jimmy said softly, "You could bring a picture."

After another pause in the action, Allie reached into her pink plastic purse and removed a tattered photograph. Her action spurred the others to form a semicircle around her so that each could get a good look at the snapshot she held of her smiling father.

The group learned weeks later that Jimmy knew the feeling that comes with being an annoyance to almost everyone. When asked for his own impressions of what his teachers thought of him, he hesitated and shrugged. But after a moment or two his cheeks reddened, and, with his mouth forming an ironic smile, he said, "They all hate me."

In this example, the principle of welcoming the whole person and valuing members as helpers is stimulated as the group worker steps aside, tacitly inviting full participation, and enabling the group to respond to Allie's lament, "I know what I'd like to bring, but I'd have to dig him up." As a result, Jimmy stepped forward with a touching sensitivity, typically hidden from the view of others in his day-to-day interactions.

Principle 3: Integrate Verbal and Nonverbal Activities

Competent group work requires the use of verbal and nonverbal activities. Group work practitioners must, for once and for all, learn to relax and to abandon the strange and bizarre belief that the only successful group is one that consists of people who sit still and speak politely and insightfully.

Activity is more than "tool," more than programmed content, more than "canned" exercises, and more than a mechanistic means to an end. In addition to a wealth of structured resource material available (e.g., games, exercises, and curricula), there are activities

that grow spontaneously out of the living together that the group members do. These are the creative applications, the member- and worker-initiated innovations that can be cultivated and brought to life in the group, contributing to a growing sense of groupness and rich history of experience together. A simple homework assignment in the changing-family group, illustrated in the previous section, led to a profound moment and empathic connection for Allie, Jimmy, and their fellow group members who had lost so much in their young lives.

In the following example, the experience of a group of depressed and sullen young adolescent girls was transformed by a “mindful” activity. In this illustration, the power of mindfulness is brought to life through the girls’ reluctant visit to an organic garden (Malekoff, 2014).

A Trip to the Organic Garden

A group of five Latina girls, ages 12–15, met in a community-based mental health center after being referred by their schools. The girls were depressed and suicidal upon referral. They were enrolled in a weekend Hike for Health Program that was designed for depressed adolescents. They did not like the rigor and routine of the weekend hiking program. Following is an illustration of one of the hikes, as narrated by one of the girls’ group workers, a Latina woman.

“On one Saturday morning I (group worker) told the girls that they would be going on a ‘different kind of hike this morning.’ The girls just rolled their eyes. When they asked more about it, I just said, ‘It’s a surprise.’

“They boarded the bus with a group of boys who also joined on the hikes. The boys were their age, but emotionally much younger and more immature. Consequently, there was no sexual tension on the trips. The girls did have some fondness for the boys, who had developmental disabilities. They treated them like younger brothers.

“As they found their places on the bus, Maria and Inez looked at one another and said, in unison, ‘I hate this.’ Neva demanded to know where they were going, and so I told them they were on their way to an organic farm. The girls looked irritated. It was a dark, damp, and dreary day to begin with. When Neva heard about the destination, she said, ‘I’m too through with this.’ Soon they were all quiet and brooding. They didn’t look angry, just irritated and annoyed.

“When the bus pulled up to the entrance to the farm, Raquel was incredulous, wondering, ‘Why am I here?’ But as they got a little closer and scanned the farm, they became curious.

“‘Hey, what is this all about?’ asked Neva. Neil, the farm manager, gave a lecture on co-ops and organic gardens and the benefits of healthy foods. They seemed more interested than anyone anticipated, especially given their attitudes on the bus ride over.

“Soon they were directed to walk through rows of crops. They seemed to like it; everything started opening up. With natural scents of the garden, their senses came alive. They were told they could touch, and they were encouraged to feel the vegetables. After all, this was not a ‘Please Don’t Touch’ museum. It was a ‘Please Do Touch’ organic farm.

“The girls were introduced to vegetables that they recognized from their trips to the grocery with their moms. But this was the first time that they were experiencing them as crops. In addition to touch, they were given permission to taste the crops. As their senses came to life, so did they. When they cracked open the crops, there was an even stronger pleasing scent.

“They looked, smelled, touched, cracked open, and tasted. ‘What is this?’ they asked when they encountered an unfamiliar herb. They were gradually transported into another world that was new but, they discovered later, was familiar. I wondered about that, too.

“There were few restrictions. They were free in this place. The girls were taken in by the newness of everything. I could see that there was something happening in their bodies as their sensory pathways were opened up in this place.

“In time, they were guided to baskets that they were tasked to fill with cherry tomatoes. Soon they became competitive, checking one another to see how their fellow group members were doing and who got the biggest tomatoes. ‘Where did you get those?’ asked Reina. Raquel pointed proudly and said, ‘Over there!’ They seemed pleased and proud that they were picking them for other visitors to the farm who paid for them to take home to their families.

“I observed a competitive camaraderie emerging—a distinct feeling of accomplishment and desire to include their peers in the process. Team building was happening naturally. There was no aggression or attitude, just friendly competition and collaboration. Each one’s success contributed to the success of the group as a whole. They picked and gathered a few other crops and then moved to a new challenge.

“Next, they were guided to a chicken coop. The chickens were protected from the foxes by being enclosed in barbed wire fencing. I could tell that they loved the idea that these vulnerable animals were protected in this special place. There was something about vulnerable creatures being protected that touched something in them.

“I decided that there was no reason to probe any of this and ruin the mood. Sometimes it is better to remain silent, observe, and encourage (rather than add insight to injury). The girls were encouraged to go inside to touch the chickens. Some were afraid. They had to go over barbed wire and help one another in the process. ‘I’m not going.’ ‘C’mom, I’ll help you, c’mom.’ Their interest in the chickens was intense. They seemed surprised, even shocked, that people would take the time to help vulnerable creatures.

“Inez said that her father killed chickens to put food on the table. She seemed very conflicted. She loved animals, and now she was in a place that protected them, in contrast to what she experienced at home.

“The girls’ mood had changed dramatically from the time they boarded the bus to the time they spent with the crops and chickens. I knew that the alternative to this trip was that they would be home alone in their rooms doing nothing and feeling depressed. And now they are alive, their senses are alive. As we talked a bit, they understood that, although they had fought with their parents who had pushed them to come to this place, they were grateful for their insistence. It created some conflict, seeing that their parents had sent them to this great place. ‘I like it here!’ beamed Elena. The girls started the process of grappling with the reality that their parents, with whom they were often in conflict, had made a good choice for them by having them visit the organic farm.

“Some of them also made a connection between their parents and grandparents and farming. Neva pointed to an unusual herb and told the others, ‘I know what that is, my grandfather grows that in El Salvador.’ That moment of recognition created a sudden spiritual connection for Neva and the others; something special, shared with parents, an agricultural legacy that came alive in this moment in this special place that they did not want to come to just a few hours earlier.”

In the *organic garden*, mindfulness was achieved through the natural process of introducing group members to a new environment, on new ground (literally and figuratively), where their moment-to-moment experiences were transformed, leading them to fully

embrace their senses of sight, smell, sound, touch, and taste. You might say that after a short time in the organic garden, the girls were “in the zone,” a place they were not very familiar with but that they welcomed when they arrived.

The unexpected experience lifted their spirits, brought them joy in the moment, sharpened faded memories of their homeland, and generated expressions of gratitude for their moms and dads who had insisted that they come to this place. No amount of probing or conversation alone could have achieved the results that, in this case, led to the delight and surprise of such a transformative experience. Engaging their minds, bodies, and all of their senses created a deep level of knowing that allowed the girls to integrate information and experiences instantly and with very little effort.

This experience, a stroll through an organic garden or a walk through any natural environment, for that matter, speaks to the restorative value of the activity. It is an example of an effortless activity that calms the brain and unplanned concentration that holds one’s attention and allows for reflection; it is what psychologists refer to as *involuntary attention*.

Principle 4: Decentralize Authority and Turn Over Control to Group Members

Group workers need to understand that losing control is not what you want to get away from; it’s what you want to get *to*. What this means is that when control is turned over to the group, and when the group worker gives up his or her centrality in the group, then mutual aid can follow, and members can then find expression for what they have to offer, something valuable to contribute to the group. Encouraging “what they have to offer”—that is the kind of group work we need to practice; that’s what real empowerment is all about.

Following is an illustration of adolescents confronting substandard bathroom conditions in a school for students with serious emotional disturbance (Malekoff, 1999).

Pink Soap and Stall Doors

“Who the fuck wants to take a dump with no privacy?” asked an exasperated Patrick, flailing his arms wildly in frustration.

The other members of Manasora High School Young Men’s Club, sitting shoulder to shoulder around the perimeter of the group room, nodded affirmatively. Patrick hoisted his electric guitar, plugged in the amp, and furiously pawed the strings, generating explosions of discordant sound that seemed to cry out, “DAMMIT, WILL SOMEBODY LISTEN TO US!”

Being heard and really listened to was rarely experienced by the dozen boys who composed the Young Men’s Club. Some saw them as castaways, shipped out to Manasora, an alternative school, after their local schools threw in the towel. They ranged in age from 15 to 19, representing as many ethnic groups and shades of color as there were members. Each had done at least one tour of duty in an inpatient psychiatric setting. They knew about life on the edge and what being misunderstood, rejected, and isolated was all about. They were familiar with the eerie and disconcerting sensations associated with feeling alone among others. But not in this crowd, this group. Not now. They felt connected to one another. On this day, they were angry and united—outraged.

Marshall jumped up, “Do you think they have any idea how humiliating it is to go to the bathroom with no doors on the stalls? There’s no privacy; it’s embarrassing. It’s like they don’t trust us; they’re treating us like little boys. . . .” In the midst of Marshall’s searching for yet richer hues with which to paint his portrait of frustration, Bernard filled the gap, adding, “It’s disrespectful, that’s what it is—it’s disrespectful.”

Then Matthew, getting back to basics, pointed out, “Man, it’s a lot of pressure when you gotta go bad and you know you can’t (in this school).”

Patrick leaped in between the intermittent guitar bursts with his own throaty plea, “It says ‘Boys’ Room on the bathroom door! We’re men! Dammit! What kind of shit is this anyway!”

The Young Men’s Club was on a roll. Stories about high school bathrooms are legion. You’ve probably heard them all: smoking in the boys’ room, cherry bombs in the toilet, shakedowns for lunch money, and so on. Song lyrics have been penned detailing escapades and horrors of high school bathrooms. But this wasn’t about anyone else’s memory or popular song of days gone by. This was *their time* and *their story*. It was *their turn* to be heard.

One of the boys who had been quietly listening asked a question. Felix was mild mannered compared with some of the others. Nevertheless, they all made space for Felix like no one ever had before. In an earlier meeting, when Molly (group worker) asked the members to name someone who was important in their lives, it was Felix who detoured from the narrow path that led to moms, dads, aunts, uncles, and grandparents. When it was his turn, Felix whispered to his fellow club members, gesturing to them with a sweeping outstretched arm, “It’s you who are important to me. It’s you. You are important to me. This group is important to me.” And now Felix would show the others what Molly already knew—that Felix had the flexibility to tap into outrage as well as affection.

Felix asked the others if it was true that kids urinated into the soap dispenser. Ronnie said that he saw someone do it, but no one could really tell until it was too late because the soap is yellow. This time, with his music and words in sync, Patrick sang out, “We have to get them to put pink soap in the dispensers! Then we’ll know if anyone pisses in there. Then we’ll know.”

Molly, listening intently, suggested that they make a list of concerns. Always dependable Matthew, sitting in the swivel chair behind Molly’s desk, grabbed a pen and started to organize a list as the others voiced their concerns in rapid-fire succession.

Improvements for the Bathroom

Soap—pink, not yellow
Toilet paper—three-ply
Doors with locks on the stalls
Only boys in boys’ bathroom
No faculty—especially teachers
Door closed
Toilet cleaner—2000 Flushes with no bleach
Functioning sinks
Roach spray and traps
Softer paper towels

A program administrator, Mr. M., upon learning about the group, commented to Molly, “It’s great to see them generate a head of steam.” He was impressed that they were confronting the uncomfortable conditions they had been merely tolerating on a daily basis. They rehearsed how they would present their “demands” to the principal and made an appointment to see her.

One day many weeks later, Mr. M. returned to the high school after the dismissal hour. He headed down a long vacant hallway to attend an administrative meeting. As he proceeded, something told him to turn around. He did. He took a few steps back down the hall, pushed open the “Boys’ Room” door, and peered in, pleasantly surprised to find pink soap in the dispensers and doors on the stalls.

Participating in a change effort that includes identifying a problem, exploring it in some depth, seeking solutions, and implementing them is an important learning experience for young group members trying to make sense of the world and a good practical lesson about the problem-solving process. By decentralizing authority, the group worker successfully enabled the group to effect change in a very concrete way.

Principle 5: Develop Alliances with Relevant Other People in Group Members' Lives

Group workers involved with children and youth must understand that anxious and angry parents, teachers, and school administrators are not our enemies and that we must collaborate with them and form stable alliances with them if we are to be successful with their children. We must learn to embrace their frustration and anxiety, rather than becoming defensive and rejecting. Alliances are needed with relevant others who are deeply invested in the plight of our group members.

The example to follow also illustrates Principle 3, *integrating verbal and nonverbal activities*, in groups and shows how members with different skill and competency levels can work together if program content is carefully chosen. The setting for this illustration is a therapeutic elementary school program. In group work with youth in intensive contexts, including inpatient settings, the importance of a good interrelationship among team members and between team members, parents, and children should be noted. This is essential in ensuring that dysfunctional patterns of communication are not replicated in the treatment setting.

A Poetry Club for Kids

A group work service for a classroom group in a special education school setting presents group workers with a unique set of challenges. One group worker knew that he needed to contract with the classroom teachers, integrate group purpose with academic and behavioral goals, and support the prosocial values promoted daily in the classroom. He thought that a poetry club (Malekoff, 2002) could build spirit, tap students' creativity, provide an alternative and fun means of expression, and cultivate an appreciation for poetry that could extend beyond the life of the group itself.

The classroom composition in the program was six students, one teacher, and one aide. At the time, three students were in each of two classes, one older and one younger class. The worker asked them to think about the concept of "poetry in motion" and explained that all poetry didn't have to be regimented pencil-to-paper work and that together they could help the students discover means for finding poetic expression verbally, musically, and physically, as well. For example, one of the group activities involved photography, with members taking turns to arrange the group into their own unique poetic tableau to be preserved photographically.

The group worker presented the idea of mutual aid as a core principle. Older students could help the younger ones, and younger ones could encourage the efforts of the older ones. The staff could easily relate to the prosocial value of promoting mutual aid.

The teachers provided a list of academic goals representing the grade level of students in their classes. Samples of the stated goals are: *students will learn to comprehend a story; students will learn to listen to and enjoy stories; students will recall important facts and ideas; students will learn to read orally with phrasing and expression, pacing, and volume; students will express personal opinions about readings*. It is important to work collaboratively with teachers and to respect the goals they wish to accomplish

and the standards they aim to maintain if one expects to be a welcomed guest in their classrooms. In reviews with the teachers, it became clear that academic goals were compatible with group purposes and goals.

The purpose and goals of the group were conceived as follows: *The Poetry Club is a weekly group that is about learning to work together, share, have fun, and build confidence through the self-expression of poetry. The goals of Poetry Club are related to academic goals, including following directions, participating in discussions, and reading aloud fluently and accurately. The Poetry Club members will learn to help one another, applaud one another, and appreciate one another.*

The Poetry Club met once a week over 10 weeks for about 40 minutes each session. The group meetings began with a reading of a “guess what” poem—poetry that described something for them to discover together. Key words were left out of the poems to create mystery. The group’s assignment was to guess what the poem described. After the poem was read, the group was instructed to huddle up, as a football team might, and discuss what they thought the poem was about. Finally, when the members thought they had arrived at the correct answer, they would say so. The first poem was about a giraffe. An added bonus was that the poem itself was shaped like a giraffe. A longer-term project was guided poetry. The members were given open-ended sentences to complete about themselves and their fellow group members that probed their thoughts, interests, experiences, and strengths. The raw material was drafted as a “poem under construction,” and each week the members would work toward the goal of refining their poem into a finished product to be included in a group-ending Poetry Club journal that would record all of their work.

Allowing adequate time for a good ending is essential. In a short-term group such as the Poetry Club, members should be reminded of how many group meetings are remaining from the very beginning and along the way. This can be done verbally or on a calendar for those members who are more inclined to integrate information visually. By providing reminders in a thoughtful manner, the end of the group does not come unexpectedly to the members, and planning for a meaningful separation is made possible.

The last three ending-phase meetings were bittersweet, with the members enjoying readings from the Poetry Club journal, chronicling their good work. The younger boys, in particular, loved gift-wrapping extra journals that they would bring home to their families. Free access to scissors and Scotch tape was heaven for the 5-, 6-, and 7-year-olds. The boys openly wished that Poetry Club could continue and questioned why it had to end. Transition. Separation. Loss. Not an easy subject for this group.

Along the lines of advocating for a group service in a school or other system, group workers practicing strengths-based group work need to maintain a dual focus of individual change and social reform. This principle has been illustrated in the creative arts group that aimed to raise consciousness about homophobia in high schools. The next two examples provide further illustrations.

Principle 6: Maintain a Dual Focus on Individual Change and Social Reform

Group workers must stay tuned in to the “near things of individual need and the far things of social reform” (Schwartz, 1986). This dual vision was first conceptualized by one of the earliest group work researchers, Wilbur Newstetter (1935). Group workers must help group members to become active participants in community affairs, so that they might make a difference, might change the world one day where others have failed. A good group can be a great start for this kind of consciousness development and action.

Taking Action against Cyberbullying

One teen group in Harlem, New York, Teen Pact, has taken steps to raise consciousness and combat cyberbullying (Alvarez, 2013). They produced public service announcements (PSAs) that are being used nationwide.

The facts are that between 20 and 56% of young people are either victims or perpetrators of bullying or both and are consequently at risk for depression, suicide, fighting and self-harming (e.g. cutting; Hertz, 2013). The Centers for Disease Control and Prevention (CDC) convened an expert panel on bullying and its relationship to suicide in September 2010. The panel's work was published in a special supplement of the *Journal of Adolescent Health* in July 2013. Three central themes emerged:

1. Bullying among youth is a significant public health problem; it is prevalent and frequently has detrimental effects.
2. There is a strong association between bullying and suicide-related behaviors, but this relationship is often mediated by other factors, including depression and delinquency.
3. There are public health strategies that can be applied to the prevention of bullying and suicide. (Hertz, 2013, S1)

Teen Pact illustrates that an effective public health strategy can involve mass public education, organized by a group of teens prepared to creatively stand up and fight back against cyberbullying. In one of Teen Pact's PSAs, a boy texts an intimate message of his affection for a classmate. He is then humiliated when the object of his affection forwards the message to her friends, who then pass it on to their friends, and so on and so forth. In no time the boy's most personal feelings have gone viral. He then becomes the subject of teasing and taunting by his peers. The PSA message is "It's not funny anymore. Don't be an accidental bully." The teen antibullying producer, 16-year-old Desiree Orellana, stated that the purpose of the group's efforts is "to make teenagers aware that you are hurting other people's feelings, and that not everything is a joke or for laughing out loud" (p. A33).

Making Gentle Waves: Stars of Hope Post-Hurricane Sandy

In the aftermath of Hurricane Sandy (October 29, 2012), in Long Beach, New York, students at Long Beach Catholic School created brightly-colored wooden stars of encouragement and posted them on utility poles around the city. Following is a sample of what some of them say: "Our prayers are with you," "Stay strong," "Think of the future," "Joy," "Love," "Dream," "Hope takes courage," "Bruised but not broken," "Celebrate," and "Strong beach."

Through this simple act of support these students lifted people's spirits. How do I know this? They lifted my spirits. I live in Long Beach and evacuated after the hurricane. I was displaced for 6 weeks, and I returned to a home in which the entire contents of the first floor were destroyed. My city also lost its iconic 2.2-mile boardwalk that overlooks the Atlantic Ocean. My hometown was devastated, and nearly every resident suffered extensive damage to their homes.

My bicycle was submerged in salt water. Fortunately, I was able to salvage it and have it repaired. On my first bike ride around town, months after the hurricane, I spotted the stars of hope on the telephone poles and trees around town. I stopped at each one to read them and take photos, which I later posted on social media sites such as Facebook and Instagram.

“Disaster is by its very nature a collective event, replete with private sorrows” (Miller, 2012, p. 283). By making gentle waves, the students of Long Beach Catholic helped me—a survivor of a natural disaster—feel better, more hopeful, and encouraged that there would be a better day.

Participating in a change effort that includes identifying a problem, exploring it in some depth, seeking solutions, and implementing and evaluating them is an important learning experience for young group members trying to make sense of the world and a good practical lesson about the problem-solving process (Malekoff, 2014, pp. 170–189).

Principle 7: Understand and Respect Group Development as a Key to Promoting Change

Each good group has a life of its own, each one with a unique personality—what group workers refer to as a culture. All those who work with groups must learn to value the developmental life of a group. A greater understanding of and respect for group development, amidst the noise and movement and excitement of a typical kids’ group, can lead to a feeling of greater confidence in the group worker, confidence that he or she will move ahead and hang in there and not bail out, as too many an adult already has.

A vital tenet of group work practice is that “the worker must actively understand, value, and respect the group process itself as the powerful change dynamic that it is” over time and in each meeting (Middleman & Wood, 1990, p. 11). This tenet demands that the practitioner have a good knowledge base, reinforced by practice experience, of group developmental theory. Group developmental theory refers to group dynamics and tasks that are unique to progressive stages (or phases) from the first to last moments of a group’s time together. Group development reflects a group’s path toward closeness, interrelatedness, and, ultimately, separation. Group development is not always a neat and orderly process. A group is subject to regression when it confronts obstacles and crises.

Three distinguished developmental models, Schwartz’s interactional model (Berman-Rossi, 1994; Gitterman & Shulman, 1985/1986), the Boston model (Garland, Jones, & Kolodny, 1973), and the relational model (Schiller, 2009), a variation of the Boston model, are good starting points. Follow is an illustration of an elegant ending to a group that I once worked with (Malekoff, 2011).

Won’t You Play a Simple Melody . . . ?

In one mixed preadolescent group, the members spontaneously decided to sing songs as part of their ending time together. Most chose contemporary songs with themes that had to do with “saying goodbye” and that they bravely performed despite various talent levels. Some chose silly songs that brought lots of laughter to the group. These included parodies by “Weird Al” Yankovic, the most famous contemporary performer of the genre. No attempt was made to interpret any of their songs. What they had created was a sort of spirited ending ritual that the group worker did not want to step on, control, or contaminate.

For the group worker, the most moving “performance,” which seemed at the time to come out of nowhere, was by 10-year-old Ronnie, who had witnessed his mother’s murder. He sang an old-time song that struck a different chord than the other songs. As the group worker listened, she imagined that it was a song that his mother had sung to him and that maybe her mother had sung to her. As he started to sing, the other members grew quiet and gave Ronnie the space that he needed. He choked on the word

mother the first time, but continued through until the end, with his sweet smile and soulful eyes: “Won’t you play a simple melody, like my mother used to play for me? One with good ol’ fashioned harmony, like my mother played for me?”

In the end, the worker must reach for his or her own feelings about the impending separation, including one’s own personal history as it relates to loss. Awareness of associated feelings and experiences can greatly assist the worker during the separation stage. The practitioner’s openness and authenticity about the coming loss, expressed with good judgment and timing, will contribute to a meaningful parting under almost any circumstances. Conversely, the worker’s unacknowledged ambivalence about separation can greatly compound the process.

Understanding that the group has a developmental life of its own enables group workers to gently invite trust, aid group members to explore and establish norms, cultivate the intimacy that shared activity and action can bring, invite free expression as the members’ own unique gifts spring forth, and help the group to say goodbye in a meaningful way in the end (Malekoff, 2014, pp. 221–235).

CONCLUSION AND FUTURE DIRECTIONS

This chapter presents a strengths-based framework for group work with children and adolescents. Seven principles were offered to serve as a foundation to inform practice so that it can be flexibly and purposefully practiced regardless of chosen model, approach, or curriculum.

Group workers who rely on curricula, agendas, and exercises require accompanying knowledge and skill necessary to promote interaction, mutual aid, and spontaneity among group members. Otherwise, rather than curriculum-guided tools, these activities then become curriculum-driven procedures. Without a good practice foundation, packaged approaches risk controlling children and youth by inhibiting creative expression.

The strengths-based principles are overlapping and interrelated. They call for group workers to consider the felt needs of group members, to recognize and activate what group members have to offer, to use a variety of activities and media to engage and challenge children and youth in groups, to reach out to parents and relevant others in group members’ lives, to recognize opportunities for group members to practice social action and citizenship, and to become familiar with the developmental paths of groups.

The future of group work with children and adolescents relies on educators and practitioners who advocate for integrating group work values, knowledge, and skill into youth development programs and the classroom. Connectedness—attachment to peers, teachers, and other relevant adults in young people’s lives—is a good educational and public health strategy that promotes strengths in young people.

Regardless of the problem to be addressed or the theoretical approach, group workers should be mindful that children and adolescents want to be taken as whole people with something to offer as opposed to broken objects to be fixed. Tuning in to and grounding oneself in the seven principles of strengths-based group work is a good starting point.

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CHAPTER 16

Group Work in Child Welfare

BARBARA RITTNER

The function of child welfare is to ensure that workers evaluate incidents of potential maltreatment, supervise children deemed at risk for ongoing abuse and neglect, develop effective services to reduce reoccurrence of maltreatment, and discharge those children believed to be safe (Rittner, 2002; Rittner, Affronti, Crofford, & Schwam-Harris, 2011). Almost everything that happens in child welfare settings happens in groups of one sort or another. Child welfare organizations are composed of groups of administrators, supervisors, workers, and support staff. Child welfare personnel often interact with a variety of service vendors, court personnel, and treatment professionals. Foster care workers and foster, shelter, and adoptive parents are trained in groups. Many of the children who come under supervision are temporarily placed in group shelters, admitted to residential facilities, or placed in relative and nonrelative foster families where groups of foster and other children live. Some are transitioned into small group homes or independent living settings. Case planning occurs in groups composed of interdisciplinary team members consisting of child welfare workers, mental health professionals, school and court personnel, and a host of allied professionals who are involved in assessments and treatment planning for at-risk children and their families.

It is not uncommon for child welfare clients to be treated in traditional remedial groups, most of which focus on addiction, parenting skills, anger management, mental health issues, and domestic violence, and all of which are likely to be open ended (Galinsky & Schopler, 1989). Despite the ubiquity of groups and group processes in child welfare settings, little has been written about how group dynamics in these settings delimit reoccurrences of maltreatment and how failure to attend to group dynamics may create barriers to effective interventions. Much of what we need to know about these groups can be derived from other sources—that is, from the literature about work and treatment groups.

Much of what happens in child welfare relies on the dynamics inherent in task group membership and processes (Gist, Locke, & Taylor, 1987; Mathieu, Tannenbaum, Donsbach, & Alliger, 2014). There is a paucity of literature evaluating group dynamics in child welfare beyond evaluating training effectiveness (Dorsey et al., 2008). Although those professional

group leaders engaged in treatment groups are aware of the power of group interventions for people with abuse and neglect histories, few child welfare agencies evaluate their own group processes in providing services to at-risk children and families. This chapter discusses the role of work, treatment, training, and focus groups within the context of child welfare settings. It discusses the group practice skills needed by administrators, unit supervisors, child welfare workers, mental health social workers, trainers, and evaluators to enhance the effectiveness of child welfare services.

AGENCY-BASED TASK GROUPS AND FOCUS GROUPS

Lohmann and Lohmann (2002) observed that administrators, in general, are responsible for providing leadership and oversight, for making decisions, and for building an organization. The ability of child welfare organizations to meet the complex needs requisite to protect children largely depends on how well and how creatively these administrative groups transcend organizational silos to address the complex issues and constant shifts in service demands. Jung and Sosik (2002) make the case for the benefits inherent in expanding membership, as well as role and rank diversity, in carefully composed work groups, a position supported by Dixon and Hart (2010), as long as the leadership embraces a broad acceptance of opinions and strategies. One of the greatest challenges faced by child welfare agencies in developing widely representative groups to create innovative and more effective strategies to protect children are the constraints imposed by legislative mandates around confidentiality (Thomas, Kohli, & Choi, 2014).

Middle- and upper-level managers in child welfare agencies can use effective group work skills to increase work flow, coordinate services, and evaluate performance in concert with federal and state policies and procedures. Regrettably, most administrators conduct business *in* a group of employees rather than utilizing group process. They fail to develop the strengths of group dynamics inherent in the ever-changing membership of new hires, promotions, and resignations (Ephross & Vassil, 2005). Facilitating proactive participation in service unit groups across hierarchical levels has been shown to enhance and promote professional growth and retention of social workers by reducing burnout, as well as improving service delivery and agency performance (Blosser, Cadet, & Downs, 2010; Smith & Clark, 2011).

Direct service units and middle managers, like their higher level administrative counterparts, also regularly meet in groups. There is evidence that active work group engagement skills can foster member ownership in the organization and can nurture an environmental culture that protects workers from burnout (Podsakoff & MacKenzie, 1997; Thomas et al., 2014). There is no question that working in child welfare is stressful. Direct service workers are exposed almost daily to abhorrent abusive behaviors and abject neglect perpetrated against children. They face unrelenting demands to dislocate and relocate children from one setting to another. At times they deal with hostile parents and demanding legal systems that may hold them responsible for predicting the behavior of others (Rittner et al., 2011). In addition, many workers labor under large caseloads in constant states of crises, with very little respect from the community for the difficult job they perform. They are generally poorly paid for their efforts, and many only stay for a few years. They experience vicarious traumatization on a regular basis that makes them especially vulnerable to burnout (Miller, Ellis, Zook, & Lyles, 1990; Rittner, 1995).

AGENCY GROUP PROCESS AND SKILLS

The more workers and line supervisors see the environment as supportive, the less likely they are to experience burnout, and the more likely they are to provide higher levels of service (Leiter & Maslach, 1988; Lizano, Hsiao, Barak, & Casper, 2014; Miller et al. 1990; Smith & Clark, 2011). There are three key elements to effective agency-based work groups: membership and roles, purpose, and process. Each of these is addressed in turn.

Membership

The first challenge that conveners of working groups in child welfare face is deciding on membership. Ironically, this is a decision that is rarely made proactively. Most often, the membership of administrative and supervisory groups is directly related to position or rank on tables of organization. It is not uncommon for child welfare administrators to meet with those who report directly to them in groups. Likewise, unit supervisors regularly meet with their supervisors, unit workers with their supervisors, and so on. In large part, this is because most of these groups reflect the ongoing business of the agency—that is, administrative, staff, and unit meetings. In these cases, membership is directly related to function and span of control.

In some cases, however, the development of an ad hoc work group may logically be considered if changing conditions require agency adaptation. Ephross and Vassil (2005) suggest that membership should be based on two principles: what the member will contribute and what benefits the member will derive from attending. This is particularly true when ad hoc groups are formed to address specific problems or issues or when groups are charged with strategic planning, goal setting, policy and procedure implementation, or program evaluations. Once the purpose of the group shifts from “business as usual” to planning or evaluative functions, then membership should reflect organizational needs in the context of a diversity of roles (Jung & Sosik, 2002). These ad hoc groups may consider resources and staffing needed to adapt to proposed or mandated changes, determine impact on roles or functions, reconfigure some structures, develop procedures, and make recommendations about where to allocate funds. Determining which potential members possess key knowledge elements, have relevant skills, or will benefit from participating will enhance the outcomes of the group process and the products of the group (Ephross & Vassil, 2005).

The inclusion of representative members in these groups ensures that constituents feel that they have had a role in the process and increases their sense of investment in the outcomes (Podsakoff & MacKenzie, 1997; Thomas et al., 2014). In child welfare, representative members may include the major stakeholders: administrators, unit supervisors, direct service workers, consumers (foster parents, adoptive parents, foster care alumni), and vendors (contract agencies, mental health providers, child evaluators). The more that those who were or are or will be doing the job are involved in planning, decision making, and evaluation processes, the greater the probability is that the goals set and procedures developed will be congruent with organizational mission, resource availability, worker capabilities, and knowledge. Equally important, barriers to successful implementation are more likely to be identified and corrected early if membership is broadly based. Finally, inclusive membership increases creativity through the diversity of opinions and reduces the potential for duplication of services (Dixon & Hart, 2010; Jung & Sosik, 2002).

Recruiting for and populating child welfare work groups can be frustrated by agency size, location, and scope. Agency-based groups are historically top-heavy and are often

perceived by line workers as limited to informing workers about new policies and procedures with little appreciation of the added burdens they carry providing services. As Glisson and James (2002) observed, cultures within organizations shape the perceptions of participants based on their function and ranks within the agency. Studies on organizational cultures suggest that there are important differences in the lenses through which administrators and line workers view systems and functions and, more important, that those lenses shape the attitudes, perceptions, and decisions made by each level. When membership reflects a more distributive power structure, the “us versus them” tensions can be delimited (Hopkins & Hyde, 2002).

Group planning activities associated with the development of strategic mapping and quality assurance groups can benefit child welfare service delivery (Joyner, 2002; Tausch & Harter, 2001). These models of decision making and quality assurance depend on an inclusionary process, with representatives from complementary functions involved in goal setting and tracking successes. The literature on these models clearly supports the importance of broad representation and dynamic group member participation in both goal setting and goal attainment. If the group target is to decrease the length of time in foster care from screening and intake to court disposition by 10% (goal setting), then the membership needs to have representatives from each of the steps in the process. Working together, they can create interval time frames needed by each of the functions (screeners, home finders, caseworkers, court personnel, etc.) to achieve the goal and establish the measures to determine whether the goal is achieved (goal attainment). The consensus-building strategy inherent in these models encourages evaluating effectiveness of service delivery beyond case reporting (Marshall, Solomon, & Steber, 2001).

With the advent of technology-enhanced groups, there are more creative ways of recruiting and engaging participation. Synchronous discussion groups are emerging as effective ways to have threaded topic discussions, conduct strategic planning, and solve thorny service problems. There are numerous online programs available to populate online interactive groups, both text based and video capture, that allow the retention of the group process and information. They can be invaluable resources that enable foster care administrators and workers to access experts more broadly. It is possible to easily expand or contract membership to create personal learning networks through online social networking services and blogs. Many of these social networking services have active professional threads that expand professional learning opportunities through access to nonlocal users (professional learning networks). These groups require clear ground rules, conveners, topic moderators, and a delivery platform.

Group Leadership Roles

Regardless of the type of agency-based group developed, designating or selecting a leader is a critical decision. In reality, the more hierarchical the agency is, the more difficult it is for leadership to be flexible. Too often the person with the highest rank is the designated leader, independent of whether he or she is the best person to lead. In child welfare hierarchies, rank has implicit and explicit power attached to it, and even leaders with good intentions can struggle to empower the members. This is particularly true for working groups that fall outside the scope of the “business as usual” group meeting.

Ideally, distributive leadership strategies engage members more fully by shifting leadership to reflect emerging needs or demands to an acknowledged expert (Ephross &

Vassil, 2005). In that case, at least one person should be understood as the convener who also facilitates group process or consensus building. Otherwise leadership is generally accepted as flexible and shifts as demands on groups change. In that case, the leadership generally is assumed by the person with the most skills or knowledge needed to achieve the task (e.g., the chief grant writer if the group is seeking grants and if that person has the most experience assembling grant applications). If distributive leadership is impractical—and there are likely to be times when it is—then how administrators and managers use the leadership role is important, especially when the group includes consumers. Effective administrative and supervisory leaders recognize the limitations of shared power and authority in naturally occurring groups, including those in child welfare agencies. They use their group work skills in order to facilitate open communication by redirecting discussions back to the group, taking a more passive role in decision making, and engaging in clarifying and summary statements. They often help the group discussions stay focused and plan for next steps. They provide acceptance of productive conflict and differing opinions while setting standards for behaviors within the group. In this way, the organization can utilize broad group representation without expecting to realize unattainable presumptions of equality.

Real-Life Example from a Foster Care Alumni Experience

The use of focus groups is an effective group method to understand participant experiences (Cochran et al., 2002). A foster care unit supervisor noticed, in the regular Friday tactical meeting “lightning round” of the week’s expected challenges and tasks (Lencioni, 2004), that workers were continuously focusing on problems with adolescents in care who were also involved in the court system and their perceptions of the complete lack of communication between the systems. Juvenile justice workers and supervisors were invited to join a focus group to explore the scope of the problems these youth faced and to understand the demands they were putting on the systems. The unit supervisor, an experienced group worker, ensured full member participation with a focus on teasing out the complexity of roles within the systems and on defining roles and role limitations so members could appreciate the demands of the various systems on service workers. Without assigning blame, the goal was to understand what these children faced and the impact their problems had on both systems. As the focus group explored the problems, it became clear that the issues spanned interagency communications, case planning, discharge, and coordination of resources. Furthermore, there was a contentious history of miscommunications and inaccurate assumptions among and between the child welfare and juvenile justice agencies about who had primary responsibility when the child was engaged in both systems.

A task force was developed with child welfare workers, detention workers, juvenile justice workers, juvenile judges, legal advocates, mental health workers, and the local school system employees. The goal was to develop more functional lines of communication and case planning coordination, with workers and supervisors identifying both the scope and the limitation of roles in general and in specific circumstances. Through a series of targeted work groups, based on the themes and elements that emerged from the focus groups, the task groups established priorities. Some met virtually and others met in person. Protocols and procedures were developed and tested, with the impact being evaluated continuously. The membership was fluid, depending on the element being addressed, and, over a period of a year, foster care youth involved in the juvenile justice systems experienced higher levels of coordinated services and fewer arrests and stays in detention.

INTERDISCIPLINARY GROUPS

The major issues to emerge in interdisciplinary child welfare groups are clarifying membership, roles, and scope and assessing for resources. Once these issues are resolved, group meetings are more likely to focus on the types of services that can be provided. It is critical that the planning stage of interdisciplinary groups includes representative membership that allows for distributed leadership so that the scope of the work and the goals established are commensurate with the best interests of clients in concert with service providers' resources. The absence of clear expectations about what members want and need from each other can create tensions that fail to address the most difficult issues. This is especially true if the basis for continuation of contracts is measured solely by success rates.

One of the most common forms of interdisciplinary groups is one in which service providers meet to discuss intervention options for child welfare families. In some cases, the services are provided to address a particular type of abuse (Campbell, 1997), and in other instances a variety of service vendors are present to explore referral options (Wagner, 1987). Toseland, Ivanoff, and Rose (1987) examined child welfare treatment conferences, a form of interdisciplinary group. The membership included representatives from child welfare, mental health settings, residential care facilities, public health, the courts, and agencies. The group members' educational levels reflected those that are typically found in interdisciplinary groups—ranging from those with undergraduate degrees to those with doctoral-level degrees (including MDs and PhDs). Their findings suggest these groups have greater treatment successes, in part because the conferences kept staff informed about client progress, reduced redundancies in services, and avoided contradictory recommendations. Furthermore, team conferences tended to provide a venue for staff to learn from each other in supportive ways.

Currently, family group conferencing (Macgowan & Pennell, 2001; Sieppert, Hudson, & Unrau, 2000) and multisystemic family therapy (Schaeffer, Swenson, Tuerk, & Henggeler, 2013) are group models heavily used in child welfare. They are interdisciplinary in nature and bring a family as a group together with service providers to develop a case plan and organize services that will delimit future maltreatment. The group leader is often the child protective services worker who has as his or her goals the brokering of services across constituencies and stakeholders and negotiating care and safety plans.

Interdisciplinary group successes are dependent on a supportive structure that includes predictable patterns within the group (Ephross & Vassil, 2005). These patterns might well include consistency in meeting place, published agendas, and distributed leadership. In many ways, the degree to which all of the stakeholders feel that their issues, concerns, and desires are being met has a great deal to do with how successful these groups are. Therefore, the degree to which the group leaders are trained as skilled group workers is an essential element that may not be adequately addressed by the sponsoring agencies.

All interdisciplinary team programs struggle with concerns about possible levels of consumer participation. In child welfare, there are additional issues. Among them is the question of who is the consumer—the child(ren), the biological parents, the foster parents, or the adoptive parents. Furthermore, there may be very tense relationships among child welfare consumers—that is, among foster or adoptive parents and biological parents. In some cases, the roles that families can assume in these teams may be uncertain. Child welfare clients are never voluntary service recipients, even if they are cooperative. Often the people in these teams have the power to remove or return children or to determine the type of services or placement that parents or children will have. Finally, in some cases, because of potential

litigation, consumers may be excluded from participation in a particular team even if generally they are included.

In summary, child welfare workers and administrators would do well to develop skills as task group leaders. The power of these groups to augment the quality of services to children and their families is often overlooked, suggesting that training components that focus on task group leadership skills should be on the agenda of human resources departments.

DIRECT SERVICES TO CHILD WELFARE CLIENTS

In a variety of venues, group services are provided to abusing and neglecting parents, to children and adolescents under supervision, and to adult survivors of abuse and neglect. This section addresses the role of group work as a means of direct remedial intervention with children and biological parents. Again, little has been specifically written about best practices for child welfare clients, but there is an abundance of research about groups that address problems shared by child welfare clients.

Group Work with Children under Child Welfare Supervision

Children who come into child welfare services often have experienced multiple levels of abuse and neglect, and those experiences predispose them to lifelong social and emotional problems (Idell & Nemeroff, 2013; Moulton, Newman, Power, Swanson, & Day, 2015; Sperry & Widom, 2013). Current research demonstrates that the earlier maltreatment occurs, the more likely the child is to develop associated behavioral and emotional problems that may well persist into adulthood (Heffernan & Cloitre, 2000; Rittner et al., 2011; Zanarini et al., 2002).

Most empirically supported group work with children in the foster care system focuses on adolescents rather than on children of latency and prelatency ages. Furthermore, children in foster care are rarely treated together in groups unless they are in a foster care group setting. More commonly, they are referred to groups because of problems that emerge as a result of the abuse and neglect they experienced—emotional or behavioral problems, as well as adjustment problems—and are placed in groups in which few if any members are in foster care.

In recent years, group treatment with a trauma-focused cognitive-behavioral therapy (TF-CBT) orientation has been shown to be effective with symptomatic children with trauma histories in order to reduce symptoms of depression and anxiety, posttraumatic stress disorder, school problems, substance abuse problems, and poor peer relations (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2014; Dowd & McGuire, 2011). Generalizing from these studies, the uniqueness of foster care experiences suggest that there could be benefits in providing TF-CBT groups for children in foster care in the light of their removal from their biological parents because of abuse and neglect and placement in a complex system of care (Cohen & Mannarino, 2008; Greer, Grasso, Cohen, & Webb, 2014; Kaminer, Burleson, & Goldberger, 2002; Smith et al., 2013).

Abused and neglected adolescents, like their nonabused counterparts, develop problems with depression and substance abuse, as well as problems associated with eventual development of personality disorders, but their treatment options are significantly different (Heffernan & Cloitre, 2000; Kaminer et al., 2002; Zanarini et al., 2002). As Kaminer and colleagues (2002) noted, adolescent participants in a cognitive-behavioral therapy (CBT)

group manifested marked decreases of depression and anxiety symptoms, reduction of substance abuse, and improved family and peer relationships. In addition, the members sustained gains in functioning during a 9-month follow-up period after leaving treatment. The issue was how best to adapt the concepts of TF-CBT to the unique experiences of abused and neglected children in foster care.

Real-Life Example: An Adolescent Foster Care Group

The foster care unit began focusing on the continuing problem with repeat runaway behaviors and the fact that judges often issued pickup orders that resulted in runaways being placed in the juvenile detention center, especially when temporary shelters were full. The caseworkers compared notes, and there was agreement that most runaways had some consistent themes: They complained about their foster parents, about losing contact with parents, siblings and old friends, about their constant moves within the system, and about their reluctance to make new friends. Others complained about being switched to new schools (some as many as four or five schools a year between placement changes and behavioral issues). Most felt that the mental health services and groups they were in did little to help because their issues were so different from most peers. As the caseworkers compared notes, they began wondering if it was possible to arrange for a group exclusively for adolescents in foster care at one of the shelters where some of the youth were residing and transporting others to it. With the approval of both agencies (child welfare and the shelter), a TF-CBT weekly group was started at the shelter for youth with three or more elopements from foster homes with the goals of increasing placement stability, minimizing the number of pickup orders when they ran away, and preventing additional juvenile charges associated with being on the streets, including misdemeanors and felony-level charges.

After a tentative start, six young people started talking about what it was like to be in foster care. By the third meeting, they wanted to know if other “kids in the system” could join. The group was expanded to 10 adolescents, with a waiting list. Members of the group talked about what it felt like to be a foster child at the mercy of a system that rarely consulted them about their placements, let alone their needs and wants.

All had experiences being labeled as a “foster” child by foster parents, teachers, guardian ad litem, judges, and clinicians, and they noted how much they resented it. They resented the insensitive and intrusive nature of most questions they were asked by almost everyone in the system, and yet they felt helpless when they were peppered with questions about details of visits with birth parents or siblings. They talked about how painful it was to lose track of siblings in the child welfare system. They despaired of their own uncertain futures.

Most had complicated relationships with their parents and foster parents, and even more complicated relationships with potential adoptive parents, that fueled their sense of being disconnected from other peers complaining about parents. They talked about running from their biological parents almost as often as they ran to them because many fantasized that their parents would be able to care for them but inevitably discovered that living with those parents was impossible. Every day they felt that they were the “only ones,” the ones without parents.

A number admitted that it had been years since they had seen their birth parents and no longer remembered them clearly. Others were not sure where their birth parents currently lived; several thought their parents might be dead; and a few had incarcerated parents that they could not visit. Many in homes worried that, if they were released for adoption, they might not be adopted. They worried that termination of parental rights confirmed that they were unwanted by their birth families, and they felt betrayed by their parents.

Over time, the open-ended TF-CBT group became a place where these adolescents belonged and where other members understood exactly what it meant to be a foster child. They were able to begin the task of restructuring how they could respond to their triggers and circumstances and increased their sense of control and empowerment. They taught each other survival skills in foster care—how to live, if necessary, like a boarder in a foster home and how to use school activities to avoid having to go “home.” They shared their knowledge about terrors of living on the streets and of dealing with the police and the courts. They compared notes on foster homes and foster parents and those that cared and those “in it for the money.” Comments on direct and vicarious trauma and abuse were slow to emerge but underlined much of their shared experiences. They supported each other with strategies to manage depression and anxiety and talked about how drugs dulled the pain but made it hard to survive in the system or on the streets. They came to group every week and, remarkably, stayed put, in part so they could attend the group.

Group Work with Biological Parents

Parenting groups are among the most common resources for abusive or neglectful parents (Shadik, Perkins, & Kovacs, 2013). Protective service workers contract with parents to attend these programs, to obtain stable employment, to submit to drug testing and treatment, and to cooperate with mental health providers. Parents are monitored for compliance with case plans and treatment through visitations to assess potential reunification (Rittner & Dozier, 2000).

The literature supports a triadic connection among trauma, alcohol, and other drug (AOD) problems and abuse and neglect of children (Blackson, Tarter, Loeber, Ammerman, & Windle, 1996; Chaffin, Kelleher, & Hollenberg, 1996; Cohen et al., 2002; Miller, Smyth, & Mudar, 1999; Rittner & Dozier, 2000; Sagatun-Edwards, Saylor, & Shifflett, 1995). Miller and colleagues (1999) found that, when women were excessively punitive toward their children, they were more likely to experience intimate partner violence, have substance use problems, and have histories of child abuse. These findings were consistent with the work of others, who report high levels of co-occurring mental health and substance-related problems (Sacks, 2000). It is possible that the lack of adequate trauma assessment of parents under child welfare supervision may partly explain why substance abuse treatment dropouts and failures are so common in that population (Murphy et al., 1991; Rittner & Dozier, 2000).

A number of established comprehensive models of group treatment have proven effective with abusive parents. Among the more promising approaches is multisystemic family treatment (MFT), an individualized family- and community-based intensive intervention to address severe psychosocial and behavioral problems from an ecological perspective. It has been shown to be effective (Schaeffer et al., 2013) as long as the programs are culturally sensitive (Herrerías, 1988). When used in conjunction with regularly scheduled home interventions, MFT has been associated with a reduction in subsequent reports of maltreatment, better parenting skills, and creation of supportive networks (McKay, Gonzalez, Stone, Ryland, & Kohner, 1995). MFT often employs a curriculum-driven group model designed to enhance a parent’s understanding of developmental issues, to challenge and modify dysfunctional parenting behaviors, to enhance anger management, to create resource and support networks, and to reinforce effective parenting skills (Constantino et al., 2001). In addition to parenting skills, some models of MFT focus on reestablishing mutual attachments between the child and parents (McKay et al., 1995).

Abusive and neglecting parents have been referred to a variety of self-help groups, including Parents Anonymous (PA; <http://parentsanonymous.org/about-us/>). PA group membership includes peer role models and professionally trained leaders as facilitators who rely on a structured group curriculum to help parents learn how to effect changes in their disciplinary behaviors (Garvin, 1987). These groups are among the few groups specifically developed to serve parents who are referred, or likely to be referred, to child welfare services. Like all self-help groups, these groups have a strong identity with mutual aid group dynamics and processes, as members connect through shared understanding of the problems they face and derive support and help from each other in solving those problems. Additionally, parents are mandated into substance abuse treatment or anger management groups on the assumption that abuse and neglect is a consequence of AOD use (Rittner & Dozier, 2000). Unfortunately, in child welfare, this may be an overly simplistic view of the dynamics of abuse and neglect in parenting behaviors (Miller et al., 1999).

The assessment and treatment of trauma in caretakers who abuse may be an important step in delimiting future abuse events. Maternal abuse histories are associated with higher levels of depression and other negative mental health outcomes and higher incidents of problems with their children (Madigan, Wade, Plamondon, & Jenkins, 2015). Once the assessment has been made, a referral to an adult survivor group may be indicated. These groups are important resources for biological parents with histories of childhood sexual abuse, as well as other types of abuse (Nesbit Wallis, 2002). Survivors commonly experience higher levels of depression, various symptoms of posttraumatic stress disorder, interpersonal relationship and social adjustment problems, and anger management problems (Madigan et al., 2015). Importantly, these consequences are just as likely to be present whether the victims experienced one or multiple events of sexual abuse (Hazzard, 1993; Heffernan & Cloitre, 2000; Zanarina et al., 2002). Survivor groups provide a safe environment in which to process traumatic events with other victims with similar experiences.

The current research suggests that CBT is effective in treating survivors. Follette, Alexander, and Follette (1991) found that when sexually abused women had prior exposure to group treatments, they derived more symptom relief. It would appear that a normalizing process occurs in these groups when trauma survivors realize that they have developed coping strategies that mirror those used by other survivors. Over time, survivors become more open to the influence of other members and begin to see them as powerful allies in shaping new self-images and coping strategies. Some study findings, however, suggest that the best outcomes are associated with many exposures to group and individual treatments over time rather than with a single group experience of a specific type (Thomas, Nelson, & Sumners, 1994). These findings reflect the fact that trauma survivors are slow to trust and share their life experiences with others.

Finally, it is important that a comprehensive assessment is conducted before mandated treatment exclusively focuses on substance issues (Chaffin et al., 1996; Rittner & Dozier, 2000). However, once it is determined that substance-related disorders are the primary problem affecting parenting behavior, then substance-abuse treatment should be pursued (see Cordova, Alers-Rojas, Perron, Salas-Wright, & Vaughn, Chapter 17, this volume).

TRAINING: GROUP-BASED LEARNING

Child welfare training for staff members and caretakers generally occurs in group settings. It is obviously more efficient to do this. Employees are usually trained in groups before

entering units, and adoptive parents, as well as foster parents, receive preservice training in groups. This section focuses on foster and adoptive parent group training models.

Formal group training for foster and adoptive parents emerged from “certification” (i.e., documentation that they and their homes met standards). Over time, it became evident that being a “parent” to foster or adopted children was very different from raising biological or even stepchildren. The failure to fully prepare parents for what they would face in fostering and adopting abused and neglected children led to high levels of aborted placements, especially in foster care (Runyan & Fullerton, 1981).

Foster and adoptive parents are trained about the various systems they and the children they foster will encounter and are trained to understand their roles in possible reunification of the children with their birth parents. These group trainings provide foster parents a way to understand the impact of abuse and neglect on children and how their trauma histories and acting-out behaviors can best be managed in a family setting. Because of these unique parenting demands, there is growing evidence that group training enhances the attitudes and skills necessary to become effective and satisfied foster or adoptive parents (Burry, 1999; Gillis-Arnold, Crase, Stockdale, & Shelley, 1998). Furthermore, membership in these groups creates a sustainable support group for parents.

Only a few studies have evaluated foster or adoptive parent training. Hampson and Tavormina (1980) published one of the earliest studies. They concluded that the best training incorporated elements of both cognitive-behavioral management techniques and psychoeducational components, as neither alone was found to be independently effective. This study was followed by a study that compared foster parents trained in groups with those trained individually in their homes (Hampson, Schulte, & Ricks, 1983). Both of these studies report that foster parents who are assigned to group trainings tend to have better attendance and to rate children’s behaviors more positively.

Since the 1980s, adoptive and foster parent training has primarily occurred in groups, with most states adopting either the Model Approach to Partnerships in Parenting Group Preparation (MAPP; Model Approach, 1987) or the Foster Parent Resources for Information, Development, and Education (PRIDE) trainings. Dorsey and colleagues (2008) described them as the “gold standards” for training and recertifying parents. The focus and content of these trainings tend to vary from program to program and from state to state. MAPP is organized around 30 hours and PRIDE around 27 hours of group training. An ancillary element of both is to help prospective parents decide whether adopting or foster parenting is for them and whether they have the attitudes and skills to be successful (Baum, Crase, & Crase, 2001). Those parents who go through the entire trainings obtain skills and attitudes believed to be associated with successful adoptions or foster parenting, particularly in skill acquisition (Burry, 1999).

Both MAPP and PRIDE use lectures, role playing, and group discussions to facilitate learning. In addition, participants are provided with “homework” assignments that are intended to help prospective parents develop insights into their potential success as foster parents. Although studies have examined the impact of MAPP training on parenting attitudes (Lee & Holland, 1991), few have evaluated possible group-process benefits. Group activities are built into each module primarily in the form of role plays and group discussions. Unfortunately, although the parents meet in groups and are trained in a group-based model, it is questionable whether the model in fact uses group skills specifically to reinforce the potential long-range mutual aid that these parents need. Hampson and Tavormina’s (1980) early study should serve as a reminder to trainers that foster parents trained in groups can benefit from the elements of mutual aid in group dynamics and processes that are incorporated into the sessions.

Real-Life Example: Group Home versus Foster Family

Once the previously cited adolescent support group was developed, it became apparent in the group that some of the problems these youth faced were directly connected to being in foster homes. Many of the adolescents in the group admitted that they preferred living on the streets or in shelters to living with foster families. A number of factors elicited those feelings. For some, the challenges of being part of another family were overwhelming after years of adjusting to one home and family after another. They had been in the system long enough or had come from such severely dysfunctional and chaotic families that the intimacy and closeness of foster family life resulted in high levels of anxiety and depression. Others noted that their foster parents did not necessarily understand the degree to which they relied on their own autonomy for survival, autonomy that the foster parents resisted, and adolescents often found themselves in power struggles with foster parents over this issue. Some admitted that feeling dependent was threatening to them. As this area of discussion continued, group members wanted to advocate for different kinds of placements for some of the young people in the group. Although independent living was theoretically an option, there were simply not enough beds, and both the caseworkers and older adolescents in the group felt that many of those programs were too highly structured.

When the caseworkers brought the issues back to the focus group of child welfare workers, juvenile court workers, and local service representatives, an expanded non-therapeutic residential care facility was considered for older adolescents transitioning into aging out of the system. The group for runaways worked on providing written feedback and handouts to trainers for foster and adoptive parents about the needs of adolescents with histories of multiple placements around issues of autonomy and discomfort with too much intimacy.

The caseworkers also brought forward a proposal generated by the foster care group members for consideration by the interagency focus group about establishing a more open, independent living program for street-based foster youth based on a drop-in model but with the option for long-term stays. The youth had already identified a possible location in a recently closed convent in the center of town near an alternative high school with a 14-bed capacity, a kitchen, and a common room that was near both schools and potential employment opportunities in fast-food businesses and warehouses. They also suggested that some of the house parents could be foster care alumni who had aged out of the system. After developing a proposal, the task group met with the diocese to consider using the closed convent as a shelter for youth who were in the process of aging out of the system before bringing a proposal to the county administration for consideration.

CONCLUSION

Foster care is a complex service delivery system that often relies on groups to provide a range of services to at-risk children. All of these groups have a primary goal to keep children safe. The achievement of this goal may well depend on the degree to which members of naturally occurring and therapeutic groups collaborate with each other to achieve the goal of reducing the risk of subsequent maltreatment. It is critical that researchers develop effective means of studying and analyzing child welfare-based group dynamics and processes so that administrators and service providers can better understand what factors in these groups contribute to meeting that essential goal—keeping our children safe.

Finally, there is a movement in child welfare to develop more empirically based practice models. People working in groups will continue to frame much of what is planned, developed, and implemented to better serve at-risk children and their families. Too often those plans do not adequately examine the role of group dynamics as central to the group's success (Bronstein, 2003). It would be helpful if research on planning and implementing groups looked at which kinds of groups are most effective with which constituencies. Inasmuch as the role of group-based decisions is likely to continue to be central to child welfare, research on how those groups contribute to the successes, as well as the failures, is key to the development of better programs to serve this population.

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CHAPTER 17

Group-Based Approaches to Preventing Adolescent Substance Abuse

The State of Social Work Science

DAVID CÓRDOVA
FRANCHESKA ALERS-ROJAS
BRIAN E. PERRON
CHRISTOPHER P. SALAS-WRIGHT
MICHAEL G. VAUGHN

In this chapter, we provide an overview of group-based approaches to adolescent substance abuse prevention with special emphases on the state of the science, as well as implications for social work research. First, we present national surveillance data on the current prevalence of licit and illicit substance use among adolescents in the United States, including ethnic and racial health disparities related to substance use. Second, we highlight the antecedents and etiological factors that shape adolescent substance use behaviors, including intrapersonal, ecological, cultural, and developmental perspectives. Third, informed by the etiological research, we discuss theoretical frameworks, including empowerment, risk and protective factors, and ecodevelopmental theory, which help guide group-based preventive interventions. Fourth, we describe three theory-driven, efficacious or effective preventive interventions that have been shown to prevent and reduce adolescent substance use behaviors, including Storytelling for Empowerment, keepin' it REAL, and Communities That Care. Although these interventions historically have not been viewed as group-based approaches to preventing adolescent substance abuse, we argue that these interventions are delivered in group settings, and therefore the need to examine group processes as potential pathways of change is warranted. Finally, we provide several recommendations to advance social work science on group-based adolescent substance abuse preventive interventions.

LICIT AND ILLICIT SUBSTANCE USE BEHAVIORS ARE PROMINENT IN ADOLESCENTS

Licit and illicit substance use among adolescents in the United States remains a public health concern. Indeed, the prevalence of substance use varies by school-based and household surveys, as well as the age-group categories. For example, data from Monitoring the Future (MTF), a school-based survey, indicate that approximately 60 and 50% of 12th graders report lifetime licit and illicit substance use, respectively (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2015). Similarly, data from the National Survey on Drug Use and Health (NSDUH), a household survey, suggest that approximately 60% of 12th graders report lifetime licit substance use (Substance Abuse and Mental Health Services Administration (SAMHSA; 2014). Whereas MTF provides data on 8-, 10th-, and 12th-grade adolescent substance use behaviors, NSDUH examines prevalence by specific age groups. More precisely, NSDUH data indicate that 8.8 and 22% of 12- to 17-year-olds and 18- to 25-year-olds, respectively, report current (past 30-day) illicit substance use (SAMHSA, 2014). Nonetheless, these data underscore that adolescent licit and illicit substance use behaviors are prominent.

Despite a recent downward trend in the United States, alcohol remains the most widely used licit substance among adolescents, with approximately two-thirds (66%) reporting having consumed alcohol (more than just a few sips) by the end of high school and over a quarter (27%) having done so by the 8th grade (Johnston, O'Malley, et al., 2015). Parallel data from the Youth Risk Behavior Surveillance (YRBS), a school-based survey, and the NSDUH suggest that between 61.7 and 75.6% of 12th graders report lifetime alcohol use (Kann et al., 2014; SAMHSA, 2014). Although the rates of alcohol use are high, even more alarming are problematic patterns of alcohol use. For example, 29.2 and 49.8% of 12th graders report lifetime binge drinking—defined as having five or more drinks of alcohol in a row within a couple of hours—and having been drunk at least once, respectively (Kann et al., 2014). Cigarette use is also relatively high, with between 34.4 and 41.1% of 12th graders who report lifetime cigarette use (Johnston, O'Malley, et al., 2015; Kann et al., 2014; SAMHSA, 2014).

Marijuana remains the most widely used illicit substance, with between 38.1 and 48.6% of 12th graders reporting lifetime use (Johnston, O'Malley, et al., 2015; Kann et al., 2014; SAMHSA, 2014) and approximately 8.6% of adolescents having used it before 13 years of age (Kann et al., 2014). In recent years, however, we have seen a sharp increase in prescription substance abuse, with between 17.8 and 19.9% of 12th graders reporting lifetime use (Kann et al., 2014).

Ethnic and Racial Substance Use Health Disparities Exist

Despite a recent decline in overall adolescent substance use, ethnic and racial substance use health disparities persist (Johnston, O'Malley, et al., 2015; Kann et al., 2014). Furthermore, developmental aspects of substance use are also important to consider as the prevalence of licit substance use among adolescent subpopulations appears to change over time. For example, Hispanics (21.8%), relative to non-Hispanic white (16.7%) and African American (21%) youth, report the highest rates of ever drinking alcohol before age 13 (Kann et al., 2014). Hispanic 8th and 10th graders, relative to non-Hispanic whites and African Americans, are more likely to report lifetime licit substance use, but these trends change by 12th grade. Specifically, non-Hispanic white 12th graders report the highest rates of current (past 30-day) alcohol use (43.6%) and binge drinking (30.6%), as compared to their Hispanic (39

and 22.7%) and African American (28.4% and 13.4%) counterparts, respectively (Johnston, O'Malley, et al., 2015).

Beyond adolescent licit substance use inequities, ethnic and racial minority youth are disproportionately affected by illicit substance use. Approximately 50.7% of Hispanic 12th graders report lifetime marijuana use, compared with 44 and 43.8% of non-Hispanic white and African American youth, respectively (Johnston, O'Malley, et al., 2015). Furthermore, Hispanic (11.7%) and African American (11.5%) adolescents, relative to non-Hispanic whites (6.5%), are nearly twice as likely to report marijuana initiation before 13 years of age (Kann et al., 2014).

To summarize, adolescence represents a developmental period for increased risk in engaging in licit and illicit substance use behaviors. Moreover, racial and ethnic minority substance use health inequities exist, and there are developmental aspects to the onset and prevalence of substance use behaviors across adolescence. Now that we have described the prevalence of adolescent licit and illicit substance use, next we discuss the antecedents and etiological factors that shape adolescent substance use behaviors over time.

INTRAPERSONAL, ECOLOGICAL, CULTURAL, AND DEVELOPMENTAL FACTORS SHAPE ADOLESCENT SUBSTANCE USE BEHAVIORS

Social work researchers have identified a myriad of factors that shape adolescent substance use behaviors. Essentially, these can be grouped by intrapersonal (e.g., attitudes, beliefs) or ecological (e.g., family, peer) factors (Córdova, Parra-Cardona, et al., 2014; Hawkins, Catalano, & Miller, 1992; Schulenberg, Maslowsky, Patrick, & Martz, 2013; Stone, Becker, Huber, & Catalano, 2012). Importantly, understanding the role of intrapersonal and ecological factors on adolescent substance use behaviors should be informed by cultural and developmental perspectives (Conner, Hellemann, Ritchie, & Noble, 2010; Córdova, Estrada, et al., 2014; Schulenberg & Maggs, 2002; Schwartz, Pantin, Coatsworth, & Szapocznik, 2007; Shih, Miles, Tucker, Zhou, & D'Amico, 2012; Soto et al., 2011). From this perspective, culture can be conceptualized as a larger system that encompasses and shapes the antecedents and etiological factors (i.e., intrapersonal and ecological) of adolescent substance use behaviors (González Castro et al., 2007; Shih et al., 2012; Soto et al., 2011; Szapocznik, Prado, Burlew, Williams, & Santisteban, 2007; Unger et al., 2002). Additionally, adolescence represents, among other things, a developmental period characterized by increased risk taking (Chen & Jacobson, 2012; Institute of Medicine [IOM] & National Research Council [NRC] Committee on the Science of Adolescence, 2011; Schulenberg & Maggs, 2002; Schulenberg et al., 2013). As such, integrating cultural and developmental perspectives into theoretical frameworks might be important to interrupt the sequelae of adolescent substance use behaviors (e.g. Chen & Jacobson, 2012). For the purposes of this chapter, we focus on those etiological factors examined as mechanisms of change in the subsequent section on efficacious and effective preventive interventions.

Intrapersonal Factors

Intrapersonal factors—including psychological, cognitive, beliefs, attitudes, and self-efficacy—shape substance use behaviors and are most proximal to adolescent development (Bronfenbrenner, 1979; Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Szapocznik & Coatsworth, 1999). Social work researchers have, for example, shown that adolescents'

attitudes toward substance use are linked to increased or decreased vulnerability and susceptibility to substance use (Beyers, Toumbourou, Catalano, Arthur, & Hawkins, 2004; Córdova et al., 2011; Duncan, Palamar, & Williams, 2014; Vaughn, Beaver, DeLisi, Howard, & Perron, 2009). For example, Córdova and colleagues (2011) found that, among a sample of delinquent Hispanic youth, poor attitudes toward alcohol were positively and significantly associated with past 90-day alcohol use, while controlling for family functioning, peer alcohol use, and school bonding.

Self-efficacy—an adolescent's perceived effectiveness in, and demonstrated ability to, utilize and carry out alternative responses to a threat and/or belief—is also important to ameliorate substance use behaviors (Bandura, 1977; Barkin, Smith, & DuRant, 2002; Choi, Krieger, & Hecht, 2013). In the context of substance use, self-efficacy can include substance use refusal skills and knowledge development. Indeed, researchers have found that higher levels of substance use refusal skills are associated with a decreased likelihood to engage in substance use behaviors (Barkin et al., 2002; Botvin, Griffin, & Williams, 2015; Choi et al., 2013; Ramo, Anderson, Tate, & Brown, 2005; Walker, Neighbors, Rodriguez, Stephens, & Roffman, 2011; Zullig, Teoli, & Valois, 2014). Investigators, for example, have shown that substance use refusal self-efficacy is associated with decreased alcohol and marijuana use in adolescents (Choi et al., 2013; Shih et al., 2012; Walker et al., 2011). Additionally, researchers have demonstrated the role of intrapersonal factors, including self-efficacy, on adolescent substance use in longitudinal multivariate designs (Ober, Miles, Ewing, Tucker, & D'Amico, 2013; Salas-Wright, Vaughn, Todici, Córdova, & Perron, 2015). For example, Ober and colleagues (2013) found that younger adolescents who report higher levels of drug use refusal self-efficacy had decreased odds of inhalant initiation over 3 years. Therefore, developing a fuller understanding of intrapersonal factors may be important to identify the variations of risk and promotive factors for adolescent substance use behaviors and to inform the development and testing of group-based interventions targeting intrapersonal factors (Alhyas et al., 2015; Córdova et al., 2013).

Ecological Factors

Social work scientists have demonstrated the ways in which adolescents' environments, or ecology, play an essential role in understanding the etiology of adolescent substance use behaviors (Connell, Gilreath, Aklin, & Brex, 2010; Córdova, Parra-Cardona, et al., 2014; Viner et al., 2012). Organized by domains or systems, this can include family, peers, school, and community (Conn & Marks, 2014; Córdova et al., 2011; Greenberg & Lippold, 2013; Szapocznik & Coatsworth, 1999; Tucker, Pollard, de la Haye, Kennedy, & Green, 2013), all of which shape adolescent substance use behaviors.

Family Factors

A substantial body of literature has shown that families play an instrumental role in shaping adolescent substance use behaviors (Wolchik et al., 2013). Córdova, Estrada, and colleagues (2014) found that family functioning—including parent support, family communication, parent–adolescent communication, parental monitoring of peers, and family cohesion—was associated with adolescent substance use behaviors. Longitudinally, researchers have demonstrated the ways in which trajectories of family functioning are associated with adolescent substance use behaviors (Kosterman, Hawkins, Guo, Catalano, & Abbott, 2000; Prado et al., 2013; Van Ryzin, Fosco, & Dishion, 2012). For example, higher or increasing

trajectories of family support were associated with decreased odds of substance use among adolescents (Córdova, Heinze, et al., 2014). Additionally, researchers have shown that family relationship quality predicts substance use from early to late adolescence (Van Ryzin et al., 2012). Several quantitative research syntheses conducted by social work researchers have shown that family-based treatments do indeed produce meaningful effect sizes for alcohol and marijuana abuse among adolescents (Bender, Tripodi, Litschge, & Vaughn, 2011; Tripodi, Bender, Litschge, & Vaughn, 2010; Vaughn & Howard, 2004).

Peer Factors

Although the family is the most proximal system to adolescent development, peers become important particularly as adolescents develop and thereby influence substance use behaviors (Allen, Donohue, Griffin, & Mitchell Turner, 2003; Connell et al., 2010). For example, adolescents' perceived disapproval by peers (as compared with indifference) and not associating with substance-using peers appear to mitigate substance use among youth (Connell et al., 2010; Mason, Mennis, Linker, Bares, & Zaharakis, 2013). Longitudinally, researchers have indicated that peers are significant predictors of substance use, even into early adulthood (Van Ryzin et al., 2012), and that effective peer-adolescent communication against substance use discourages early adolescents from substance use (Kam & Wang, 2014).

School Factors

Drawing from decades of social work prevention science, the school system, presumably one of the most important for adolescents given the amount of time they spend in this system, must be considered in the conceptualization of adolescent substance use behaviors. Hawkins and colleagues (1992), for example, identified academic failure and low commitment to school as risk factors for adolescent substance use. Longitudinal studies on the link between the school system and adolescent substance use have demonstrated that continued academic engagement has protective effects against adolescent substance use from middle to high school (Henry, 2010). Positive school climate has also been associated with lower likelihood of cigarette and marijuana association and escalation of cigarette use, but not with alcohol-related behaviors (Szmitman & Romer, 2014). Counter to what we may expect, high school sports have been linked with higher levels of alcohol consumption, but not cigarette and illicit drug use, although more research is needed to understand why this is the case (Lisha & Sussman, 2010). Research focused on the specific school characteristics, including climate, belonging, and programming, is needed to further refine current and future interventions aimed at curbing adolescent substance use.

Community Factors

Investigators have shown that the community, one of the most distal systems to adolescent development, interacts with the family, peer, and school systems and plays an important role in adolescent substance use behaviors (Mayberry, Espelage, & Koenig, 2009). For example, communities characterized by high unemployment rates and perceived discrimination among racial and ethnic minority youth are associated with greater susceptibility to adolescent substance use (Brody et al., 2012; Tucker et al., 2013). Conversely, adolescents who perceived their communities to be positive appear less likely to engage in substance use behaviors (Mayberry et al., 2009). Between 1976 and 2008, community attachment (i.e., social

trust, social responsibility, and religiosity) decreased adolescents' use of cigarettes, alcohol, marijuana, and other illicit drugs among a nationally representative sample of high school seniors (Wray-Lake et al., 2012). Longitudinal studies have also found that, for 5th-grade participants who had not yet initiated substance use, community-based interventions targeting community-level risk factors, including community loss and norms favorable toward problem behaviors, had significant effects on reducing alcohol and cigarette use by 10th grade (Hawkins et al., 2008, 2012; Oesterle, Hawkins, Fagan, Abbott, & Catalano, 2010).

Culture

Although adolescent behaviors influence and are influenced by intrapersonal and ecological factors, the impact of these factors on adolescent substance use behaviors should be grounded in a cultural perspective. Indeed, social work scientists have recognized the importance of integrating cultural perspectives in understanding the etiology of adolescent substance use (Barrera & Castro, 2006; Lau, 2006). From this perspective, culture is a larger system that encompasses all other systems (e.g., family, peer, school, community) operating in the lives of adolescents, thereby shaping adolescent substance use behaviors (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000).

A Developmental Perspective

The role of intrapersonal, ecological, and cultural influences on adolescent substance use should be examined through a developmental perspective (Conner et al., 2010). Developmental scientists affirm that adolescence represents a lifespan period characterized by increased risk taking (Conner et al., 2010; IOM & NRC, 2011; Swendsen et al., 2012), including increased susceptibility to engage in substance use (Johnston, Bachman, O'Malley, & Schulenberg, 2015; Kann et al., 2014). More recently, researchers have focused on identifying the developmental pathways that lead to substance use, including ethnic and racial differences in trajectories and outcomes (Chen & Jacobson, 2012; Conn & Marks, 2014; Conti & Heckman, 2013; Schulenberg & Maggs, 2002; Sitnick, Shaw, & Hyde, 2014). Developmental perspectives help to understand normative substance use during adolescence and its turning points or disturbances (Schulenberg & Maggs, 2002) and to highlight the need for different prevention and intervention programs tailored to the contextual needs of adolescent subpopulations (Chen & Jacobson, 2012; Sloboda, Glantz, & Tarter, 2012).

To summarize, efforts aimed at preventing adolescent substance abuse should work toward a fuller understanding of the antecedents that shape substance use behaviors. Social work researchers examining the etiology of adolescent substance use should consider intrapersonal and ecological factors, while grounding this line of research in cultural and developmental perspectives. This basic science can then be applied to the development of theoretical frameworks. In the next section, we describe three theoretical frameworks, including empowerment, risk and promotive factors, and ecodevelopmental theory.

THEORETICAL FRAMEWORKS

The epidemiology of adolescent substance use, including its prevalence and etiology, has great utility to inform the development and testing of theoretical frameworks. Investigators affirm the necessity for theory-driven adolescent substance abuse preventive interventions

(Glanz & Bishop, 2010; Schulenberg & Maggs, 2002). For the purposes of this chapter, we focus on three theoretical frameworks, including empowerment (Zimmerman, 2000), risk and promotive factors (Hawkins et al., 1992), and ecodevelopmental theory (Szapocznik & Coatsworth, 1999), as these theories inform the preventive interventions described in the subsequent section. Additionally, we provide some discussion on iatrogenic effects, which is important to consider when implementing group-based interventions to address adolescent substance use.

Empowerment Theory

Empowerment theory links the social and political ecology to adolescent well-being by employing a strengths-based approach that emphasizes wellness, competence, and strength over illness, deficits, and weaknesses (Wong, Zimmerman, & Parker, 2010). From this perspective, empowerment is a process whereby adolescents take control of events and outcomes of importance to them (Fawcett et al., 1995). Empowerment theory affirms the need to position adolescents as collaborators, including involvement in important decision-making processes, while considering their sociopolitical environments. At the community level, for example, empowerment theory can be applied to understanding collective action aimed at improving community self-efficacy through strengthening the ties between social work researchers and community organizations (Maton, 2008; Perkins & Zimmerman, 1995). This approach may incorporate both internal horizontal community building dimensions and vertical community organizing efforts to increase youths' sociopolitical control (e.g., leadership competence and policy control; Peterson, Peterson, Agre, Christens, & Morton, 2011). Wallerstein (2002), for example, demonstrated the ways in which youth-led initiatives can inform the development and content of interventions aimed at improving adolescent well-being and preventing and reducing problem behaviors. This was accomplished, in part, through increased engagement and participation, increased control and critical awareness among adolescents, and efforts to transform material conditions and build community social protective relations (Wallerstein, 2002).

Risk and Promotive Factors

Social work researchers have shown the utility of a risk-focused approach to developing effective strategies for the prevention of adolescent substance abuse (Hawkins et al., 1992). The first category of risk factors is referred to as contextual, including societal and cultural. Individual and interpersonal environments constitute the second category of risk factors. For adolescents, interpersonal environments may include families, peers, and school (Hawkins et al., 1992). From this perspective, adolescent substance use behaviors are influenced by contextual factors, which may include laws and norms influencing substance use behaviors (e.g., legalization of recreational marijuana use), availability of licit and illicit substances, socioeconomic disadvantage, and impoverished communities (Hawkins et al., 1992). At the individual and interpersonal levels, risk factors influencing adolescent substance use may include physiological, family substance use attitudes and behaviors, family functioning, early onset of child behavior problems, school-related factors, peer substance use behaviors, alienation, and early onset and favorable attitudes toward substance use (Hawkins et al., 1992). Therefore, a risk-focused approach requires the identification of contextual and individual/interpersonal risk factors that shape adolescent substance use, as well as enhancing promotive factors aimed at mitigating some of these effects.

Ecodevelopmental Theory

Social work investigators have demonstrated the importance of applying ecological frameworks to conceptualizing adolescent substance use behaviors (Córdova, Heinze, et al., 2014; Hawkins et al., 1992). Ecodevelopmental theory (Szapocznik & Coatsworth, 1999) expands on both Hawkins and colleagues' (1992) risk and promotive factors framework and Bronfenbrenner's (1979) socioecological theory and postulates that adolescents are embedded in social systems that both influence and are influenced by youth over the developmental lifespan. These interconnected and interdependent processes occur at various levels, including microsystems (e.g., individual, family), mesosystems (e.g., family–peer systems), exosystems (e.g., sibling support systems), and macrosystems (Bronfenbrenner, 1979). The microsystem, the most proximal to adolescent development, is the system in which the adolescent directly participates. This can include the family, peer, or school microsystems, among others. The mesosystem refers to the process by which two microsystems interact. For example, the family microsystem may interact with the school microsystem during parent–teacher conferences. The exosystem is the system that the adolescent does not participate in directly but that has indirect effects on adolescent development. That is, although the adolescent may not directly participate in a specific microsystem, this system may affect him or her. For example, an adolescent may not directly participate in his or her sibling's school microsystem; however, the impact of school violence on his or her sibling may have an indirect effect on the adolescent and his or her family (e.g., stressors). The most distal system shaping adolescent substance use behaviors is the macrosystem. This system may include cultural, political, and structural level aspects, such as discrimination and unfavorable views toward minority groups (Szapocznik & Coatsworth, 1999). For example, many ethnic and racial minority groups report experiencing perceived discrimination, which, in turn, may affect adolescent problem behaviors, including substance use (Brody et al., 2012; Molina, Alegría, & Chen, 2012).

Iatrogenic Effects and Unexplored Pathways

Although they are not a guiding theoretical framework for the development and testing of group-based interventions, it is important to consider iatrogenic effects when working with adolescent groups. Seminal research on group-based substance abuse preventive interventions indicate that a group format may in fact have iatrogenic effects. Indeed, researchers have shown that group-based deviancy training targeting substance use may have unintended consequences such that deviant peers may reinforce deviant attitudes and behaviors among peers (Dishion, Spracklen, Andrews, & Patterson, 1996; Rorie, Gottfredson, Cross, Wilson, & Connell, 2011). Iatrogenic effects, however, have been shown to vary as a function of developmental factors and the degree of problematic behaviors. For example, older, more deviant children appear to be most vulnerable to iatrogenic effects as compared with their younger, less deviant counterparts (Dishion, McCord, & Poulin, 1999). There are at least two plausible reasons for these unintended consequences, including the reinforcement of deviant behaviors through social interactions, as well as the fact that youth may not be engaged or perceive value in deviancy training (Dishion et al., 1999). Thus, there remains the need to develop a fuller understanding of iatrogenic effects in group-based adolescent substance abuse preventive interventions. Research focused on adolescent–peer relationships and interpersonal characteristics that may play a role in iatrogenic effects is needed but limited (Piehler & Dishion, 2014).

Although some researchers have indicated that group-based substance use interventions may yield negative consequences, several efficacious or effective family-, peer- and school-based interventions are delivered in a group context. That is, although these interventions target different mechanisms or pathways of change (e.g., self-efficacy), many are delivered in a group format (Catalano et al., 2012). However, researchers examining the effects of family-, peer-, and school-based interventions have not fully examined group processes (e.g., group cohesion) as potential mechanisms of change. Furthermore, family-, peer-, and school-based interventions delivered in group settings have been found to be efficacious at curtailing adolescent substance use behaviors, especially with adolescents who have yet to initiate substance use behaviors and who associate with nonusing peers (Valente et al., 2007).

To summarize, identified antecedents and etiological factors that shape adolescent substance use behaviors are applied to the development of theoretical frameworks. Theoretical frameworks in turn guide the development and testing of group-based preventive interventions. Although researchers have highlighted the potential for iatrogenic effects in group-based interventions among high-risk adolescents, this may not hold true for preventive interventions. Furthermore, many family-, peer-, and school-based preventive interventions have been delivered in a group format, yet research aimed at examining group processes as potential mechanisms of change remains limited. Next, we discuss theoretically driven, efficacious, and effective preventive interventions.

GROUP-BASED ADOLESCENT SUBSTANCE ABUSE PREVENTIVE INTERVENTIONS

Social work scientists affirm that optimally efficacious and effective programs are those that target multiple contexts in the adolescent's ecology (i.e., family, peer, school, community), as well as programs that incorporate multiple interventions targeting multiple contexts (Robertson, David, & Rao, 2003). Relative to family-, school-, and community-based interventions, few readily available, research-informed, group-based interventions have been developed and tested. Although Storytelling for Empowerment, keepin' it REAL, and Communities That Care traditionally have not been conceptualized as group-based interventions, we argue that these interventions are delivered in a group format. Therefore, in addition to highlighting the researched mechanisms of change for each respective program, we also suggest group processes that can be examined as potential mediators.

Storytelling for Empowerment

Storytelling for Empowerment (SFE)'s substance abuse prevention curriculum, Storytelling PowerBook, is listed as a best-practice with SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP; Nelson & Arthur, 2003) and has demonstrated evidence for preventing and reducing substance use behaviors among adolescents. Guided by the empowerment and ecodevelopmental frameworks, SFE aims to increase prevention knowledge, perceptions of harm, and self-efficacy in substance use refusal skills (Nelson & Arthur, 2003).

SFE has been evaluated in several studies. In one study, SFE was delivered as a 27-session intervention over the course of the school semester (Nelson & Arthur, 2003). The

intervention included interactive activities, culturally congruent stories, role play, artwork, writing, and interview tasks, among others. Relative to a control group, SFE was efficacious at reducing alcohol and marijuana use at 1-year follow-up (Nelson & Arthur, 2003). Building on this evidence-based foundation, Nelson, Córdova, Walters, and Szeecsy (2015) developed an HIV curriculum as part of the SFE intervention given that substance use and sexual risk behaviors often co-occur in adolescence (Ritchwood, Ford, DeCoster, Sutton, & Lochman, 2015). The researchers developed the HIV StoryBook in 2001 and tested its effectiveness with middle-schoolers who were assigned to either the control group—who received the Storytelling PowerBook substance use curriculum—or the experimental group, who received the HIV Storybook. Although youth in the control group had a higher number of contact hours as compared with the experimental group, adolescents in the experimental group reported increases in prevention knowledge, in efficacy of stopping sexual advances, and in the ability to discuss sexual topics at 4 months postbaseline (Nelson et al., 2015). While SEF is not considered a group-based preventive intervention, arguably group processes occur that have yet to be examined. For example, SEF has been delivered in school settings to a group of adolescents (Nelson & Arthur, 2003; Nelson et al., 2015). Therefore, research aimed at examining whether and to what extent group processes, including group cohesion and group support, mediate the effects of SFE on adolescent substance use behaviors is warranted.

keepin' it REAL

keepin' it REAL (kiR) is registered with the SAMHSA National Registry of Evidence Programs and Practices. A middle-school substance abuse preventive intervention, kiR is guided by narrative theory, performance theory, communication competence theory, focus theory of norms, social-cognitive theory, and the communication theory of identity (Hecht et al., 2003). kiR aims to increase drug use resistance strategies. These strategies are represented by the acronym REAL: *refuse, explain, avoid, and leave*. The kiR preventive intervention is delivered over a 10-week period with sessions lasting approximately 45 minutes each in three panel versions: Mexican American–centered version, non-Mexican American–centered version, and a multicultural version (developed by incorporating five lessons from each of the other two versions). kiR has been shown to prevent and reduce substance use among middle-school adolescents and provides evidence for the design and implementation of theory-driven, culturally congruent preventive interventions (Hecht & Miller-Day, 2011; Hecht et al., 2003). Specifically, although alcohol, cigarette, and marijuana use increased over time for both the intervention and control conditions, this increase was smaller for students in the intervention condition at wave 2. Students in the intervention condition also reported adopting more resistance strategies at waves 2 and 3 (cigarettes only), but no differences emerged at wave 4. Students in the intervention condition also experienced less erosion in their personal attitudes against substance use and significantly smaller increases in their peers' substance experimentation and use (Hecht et al., 2003). Finally, the Mexican American and multicultural versions of kiR seemed to be most effective (Hecht et al., 2003). Similar to SFE, kiR is considered a school-based prevention program, yet it is delivered in a group setting. Therefore, there remains the need to examine group processes, including group cohesion and group support, as potential mechanisms of change of the kiR preventive intervention.

Communities That Care

Communities That Care (CTC) is a community-based prevention system that is premised on engaging key stakeholders to develop and implement evidence-based approaches aimed at fostering positive youth development (Hawkins et al., 1992; Hawkins, Oesterle, Brown, Abbott, & Catalano, 2014). Informed by the risk and promotive factors framework, community-wide reductions in risks are achieved through the promotion and implementation of research-informed preventive interventions that respond to the community's contextual needs. CTC utilizes the Blueprints for Healthy Youth Development website, an online registry of evidence-based positive youth development programs, to identify those interventions that target the specific concerns of the community. With respect to adolescent substance use, we briefly describe two interventions used as part of the CTC prevention system and delivered in group settings, including LifeSkills Training and Project Towards No Drug Use.

LifeSkills Training (LST; Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995) is a 3-year middle-school-based substance abuse preventive intervention. Over the course of 3 years, LST-trained instructors teach 30 sessions (15, 10, and 5 sessions corresponding to Year 1, Year 2, and Year 3, respectively) on three major components: (1) personal self-management skills, (2) social skills, and (3) information and resistance skills specifically related to substance use through instruction, demonstration, feedback, reinforcement, and practice. LST and LST-informed interventions have been evaluated in several cohorts since 1995 and have been found effective in both short- and long-term substance use and initiation rate reductions (e.g., Botvin et al., 2015; Griffin & Botvin, 2010; Spoth, Clair, Shin, & Redmond, 2006).

Project Towards No Drug Use (Project TND) was originally developed for at-risk seniors in alternative high schools (Sussman, Dent, Stacy, & Craig, 1998), and has been shown to be effective among traditional high school adolescents (Dent, Sussman, & Stacy, 2001). Originally consisting of nine sessions, Project TND currently consists of twelve 40-minute interactive sessions delivered by teachers or health educators over a 3-week period. Project TND provides instruction in motivation activities aimed at preventing and reducing substance use and improving skills in self-control, communication, resource acquisition, and decision-making strategies. Project TND utilizes the Socratic method, such that instructors use questioning leads to facilitate interaction between the instructor and adolescents and between adolescents and their peers. Project TND has been found to effectively reduce substance use up to 5 years postintervention (Sun, Skara, Sun, Dent, & Sussman, 2006).

CTC's success, including implementation in the United Kingdom, the Netherlands, Canada, and Australia, among others, can be attributed in part to its flexibility in determining the interventions that best suit the needs of the community and the promotive and risk factors youth face (Hawkins et al., 2009). Here, we provided two examples of potential interventions that can be implemented as part of the CTC approach, including LST and Project TND.

To summarize, Storytelling for Empowerment, keepin' it REAL, and Communities That Care are theoretically driven programs that have been shown to be efficacious or effective in preventing and reducing adolescent substance use. Although these programs have not been framed as group-based interventions, they are delivered, in part or in entirety, in school settings and/or group formats, and therefore there remains the need to examine group processes as potential mechanisms by which change occurs.

RECOMMENDATIONS FOR ADVANCING THE SOCIAL WORK FIELD

Based on the current state of social work science on group-based approaches to prevent and reduce adolescent substance abuse, including the prevalence, etiology, theoretical frameworks, and intervention programs, we offer recommendations on the ways in which to advance the field.

From an epidemiological perspective, there remains the need for social work investigators to develop a fuller understanding of the ways in which the homogeneity and heterogeneity of substance use prevalence and antecedents vary within and between adolescent subpopulations. Historically, large-scale epidemiological studies focused on adolescent substance use trends have been conducted by researchers in fields such as public health and psychology, with few social work researchers engaging in these lines of investigations (Perron et al., 2009; Vaughn, 2011). This program of research may advance the social work field by highlighting adolescent subpopulations that are at increased risk of engaging in substance use behaviors. Such research, for example, could examine racial and ethnic subgroup differences aimed at informing health disparities programs of intervention research. For example, while surveillance data has indicated an increased risk for substance use among Native American populations (Whitesell, Beals, Big Crow, Mitchell, & Novins, 2012), Native American youth have not been well represented in national representative studies (e.g., Youth Risk Behaviors Surveillance). Furthermore, research examining within-group racial and ethnic subpopulations disproportionately affected by substance use is scarce. Findings from the Monitoring the Future study, for example, indicate that, relative to non-Hispanic white and African American youth, Hispanic youth report the highest rates of lifetime licit drug use (Johnston, O'Malley, et al., 2015). Social work researchers, however, have highlighted that Mexican American (22.2%) adolescents—a Hispanic subpopulation—relative to Puerto Rican (16.7%), Cuban American (18.7%), and other Latin American (14.4%) youth, report the highest rates of past-2-weeks heavy drinking (Delva et al., 2005). These lines of inquiry are limited and will be helpful to advance the field of social work by informing the development and testing of culturally congruent preventive interventions. For example, although interventions have focused on heavy drinking among the general adolescent population, targeting Mexican American youth may be particularly beneficial.

There is a dearth of group-based social work preventive interventions for adolescent substance use. Therefore, developing and testing theoretically driven group-based interventions to advance the field of social work is warranted. There are at least two areas where research may help in this regard. First, there remains the need to identify mechanisms of change that are consonant with group processes. For example, group cohesion, group support, and positive peer interactions may all be potential pathways of change whereby group-based interventions have an effect on adolescent substance use behaviors. Second, relatively little research examining the long-term effects of group-based interventions on adolescent substance use exists. Therefore, advancing the field of social work research will require investigators to conduct longitudinal randomized clinical trials aimed at establishing both the short- and long-term effects of group-based prevention programs.

Mobile applications (apps) have become ubiquitous in the lives of adolescents as a result of recent technological advances. Mobile health (mHealth), the practice and dissemination of public health and medicine via the use of technology, provides innovative opportunities for social work researchers to deliver preventive interventions to adolescents. Therefore, a third recommendation to advance the field of social work is to adapt research-informed

programs into mHealth modalities. Delivering effective substance abuse preventive interventions via mHealth platforms has the potential for greater reach, including the engagement and retention of adolescents who disproportionately carry the burden of substance use. For example, approximately three-quarters of adolescents report having or having access to mobile devices, many of whom are ethnic and racial minority adolescents (Madden, Lenhart, Duggan, Cortesi, & Gasser, 2013). Thus harnessing the widespread use of technology may prove useful in reducing substance use health disparities. In fact, social work researchers have recently adapted Storytelling for Empowerment into an mHealth app (herein referred to as S4E). Employing the principles of community-based participatory research, a theory-driven and culturally congruent preventive intervention app was developed (Córdova et al., 2015, 2016). Although researchers have worked to develop mHealth interventions, including S4E, demonstrating the efficacy of these programs in preventing and reducing adolescent substance use will be vital in moving the social work field forward.

A fourth recommendation to advance the field is to integrate social work research and practice in contexts that capitalize on recent public health policy shifts in the United States. For example, significant increases in health care visits are expected as a result of shifts in public health policies. While interventions, including Storytelling for Empowerment, keepin' it REAL, and Communities That Care, have shown success in engaging youth in prevention services, many of these programs are delivered in traditional contexts such as schools. As such, social work interventionists may fail at engaging adolescents who are disproportionately affected by substance use. Therefore, integrating social work preventive interventions in youth-centered community health clinics has the potential to recruit and engage adolescents who may not participate otherwise in prevention services. In fact, social work researchers have underscored the need to deliver substance use interventions in health care settings (Lundgren & Krull, 2014). In line with recent shifts in policy and professional recommendations, developing or adapting adolescent substance abuse preventive interventions for health care settings will be essential to advance the field of social work.

CONCLUSION

In summary, substance use behaviors are prominent among adolescents. Understanding the prevalence of substance use behaviors, as well as identifying the etiological factors that shape adolescent substance use behaviors, is useful to develop and build on theory. In turn, theoretical frameworks help guide group-based substance use interventions for adolescents. While numerous family-, school-, and community-based programs traditionally have not been viewed as group-based approaches, many of these interventions are delivered in a group format, indicating the need to examine group processes as potential mechanisms of change. We provided several recommendations to advance the state of social work science, including the need to develop a fuller understanding of the prevalence and etiology of substance use among adolescent subpopulations aimed at informing theoretical frameworks; developing and testing theory-driven and culturally congruent group-based adolescent substance abuse preventive interventions; incorporating technology in the dissemination of research-informed interventions; and capitalizing on recent public health policy shifts in the United States. Overall, these areas of research should aim to address substance use health inequities and work toward health promotion among adolescents, a population at increased risk of substance use behaviors.

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CHAPTER 18

Groups for Older Adults

RUTH CAMPBELL

It has given me a place and a group to talk about very painful feelings, which in the past have led to depression, and the skills to cope with these thoughts and feelings. I am grateful.

—Ms. D, an 86-year-old participant in a mindfulness-based cognitive therapy group (Foulk, Ingersoll-Dayton, Kavanagh, Robinson, & Kales, 2014)

In recent years, the number of groups held with and by older adults has increased considerably as research has identified the multiple losses and deficits of aging, as well as the strengths and potential of this later stage of life. The settings in which groups are held have also expanded with the development of new geriatrics programs at medical facilities, adult day centers for people with memory loss, an increase in assisted living residences, lifelong learning programs, Internet and teleconferencing groups, and other community-based programs.

Two widely recognized facts about the older adult population are (1) that the percentage of Americans over age 65 is rapidly increasing and that within that population the largest increase will be in the percentage over age 85 (Administration on Aging, 2014) and (2) that the group we label as “old” are very heterogeneous, spanning at least two generations, with a wide range of health statuses, racial and ethnic backgrounds, education, income, and experience. This diversity is reflected in the many different kinds of groups involving older adults, including those that are psychotherapeutic or psychoeducational skill-building groups, support and self-help groups, recreational and creative activities groups, groups for those with a specific illness such as depression or Alzheimer’s disease, and lifelong education and community action groups.

Group work with older adults, according to Toseland (1995), developed over the early part of the 20th century in three distinct settings: settlement houses and community centers, homes for the aged, and state mental institutions. Maurice Linden (1953), a psychiatrist, was one of the early leaders, co-leading a group therapy program for elderly regressed women in a state mental institution in Pennsylvania (Ranney & Burnside, 2005). Kubie and Landau

(1953) described their experience in developing a senior center program for low-income older adults in New York. Group work in homes for the aged and nursing homes (Konopka, 1954; Shore, 1952) focused on helping residents adjust to the nursing home, remain socially active, and enhance their physical and cognitive functioning.

The two most comprehensive books in the field, by Toseland (1995) and by Haight and Gibson (2005), document how group work can be utilized by healthy, active older adults, by those with chronic conditions, and by the frail older adults with physical and cognitive impairments. Toseland (1995) notes that there are three categories of contraindications for group participation. These are (1) practical barriers such as transportation, frailty, or lack of enough people in a setting to support a group; (2) people's particular therapeutic needs, such as acute crisis situations or material too personal to disclose in a group; (3) people with certain personality or mental health problems. However, it is often possible to adapt to these challenges and to target groups especially for certain populations or to begin with individual counseling and gradually move to a group. In terms of practical barriers, in a long-term memoir writing group for seniors, for example, members who were still driving picked up those who could not for each weekly session.

Interest is increasing in the geropsychiatric literature as evidence-based models used with younger populations, such as cognitive-behavioral therapy, dialectical behavior therapy, and mindfulness therapy group methods, are adapted and evaluated for use with an older population. Research has demonstrated the effectiveness of these therapies, as well as providing some evidence that these psychosocial interventions offer broader effects and greater stability of response than seen with medications alone (Hollon, 2003). Practitioners are also drawing on existing gerontological research to explore new group options for older adults. A cognitive therapy group for older adults, an intergenerational reminiscence group, a "meaning of life" group, and writing groups are examples of groups that grew from practitioners' recognition of the special needs of their clients (Ingersoll-Dayton & Campbell, 2001).

Groups are viewed as especially powerful agents of change for older adults, uniquely suited to the challenges of the aging process: coping with loss, shrinking support networks, societal change, and chronic illness. Although recreational groups are certainly important, this chapter focuses on some of the newer interventions in psychotherapy, such as mindfulness and narrative therapy, skill-building and support groups, diverse approaches for people with dementia and their caregivers, groups using reminiscence and the creative arts, and peer-led education groups. Many of these have generated empirical evidence supporting outcomes and also point the way to future development of the field.

THE PURPOSE OF GROUP WORK WITH OLDER ADULTS

The purpose of group work, regardless of the intervention and the physical and cognitive levels of the participants, is to enable the older adult to function at the highest level possible and to push the boundaries of what the individual, family, or society at large expects from a certain person in a certain situation. Groups provide a cushion, a way to safely explore one's own identity and to forge new connections with others. For older adults, groups may often represent a surrogate family, a new network of friends, and a way to explore areas in their lives that they never had the time or opportunity to do earlier. For the leader or co-leaders, groups with older adults are a particular challenge, a balancing act between asserting leadership, providing counseling and support, and stepping back to allow the group to take

over. The purpose of the group will often depend largely on how the group defines it. The significant role of the group worker is to develop groups that are sensitive to the changing needs of this population and to the wide diversity of roles, abilities, and as yet unfulfilled desires of adults in the later stages of life.

Group work with elders often involves a more direct approach than with younger people. Leaders must take a more active role in giving information, answering questions, and sharing themselves with the group members. Leaders need to provide support, encouragement, and empathy for the unique problems that older people face. Leaders must feel comfortable with the dependency that may develop among their group members (Haight & Burnside, 2005). It's also important to pay attention to the physical comfort of group members, their energy levels, and their sensory deficits. Foulk and colleagues (2014) describe how the group leader of a mindfulness-based cognitive therapy group supplied pillows and blankets to support members' bodies during meditation exercises, shortened the length of sessions, and used a microphone to compensate for hearing loss.

Several theoretical approaches provide the framework for group work practice with older adults. Rowe and Kahn (1987, 1997), in their concept of successful aging, pointed out that many characteristics of aging, such as decreased mobility and physical and cognitive decline, that are thought to be normal stages of the aging process are actually due to lifestyle and other factors that can potentially be modified through exercise, nutrition, cognitive training, and active participation in life. The concept of selective optimization with compensation, developed by Baltes and Baltes (1990), emphasizes the variability among individuals as they age and affirms that the self does remain resilient in later life.

These concepts confront the idea that used to be prevalent, even in the professional community, that older people cannot change: "If he never joined a group before, why would he now? What can be gained from working with people with memory loss?" Groups themselves, as Yalom (1985) wrote, instill hope. The purpose of being in a group is to make some change that will enhance one's life, reinforce one's ability to cope, and build on existing strengths.

Social support is also a significant element of successful aging. Studies have shown that older people who maintain meaningful ties with others are likely to be in better physical and mental health than those who do not (Krause, 2001). As people age, they are more likely to be living alone; for example, almost half of women over the age of 75 lived alone in 2014 (Administration on Aging, 2014). Even elderly couples may find themselves isolated due to chronic illness, caregiving demands, distance from family members, and changes in their social networks. Groups offer a more structured opportunity to gradually and safely make new friendships and replenish support networks.

Aging is often depicted as a time of loss. Spouses, friends, and significant family members die, become ill, or move. Retirement may bring a loss of role, status, and income. Chronic illness, which affects about 80% of people over age 65, imposes limitations that affect mobility, transportation, enjoyment of familiar activities, and daily functioning. Sensory losses in vision and hearing, in particular, require major life adjustments, and declining memory, even in the earliest stages, challenges an individual's sense of self and identity. The proliferation of support groups to address these specific needs (groups concerned with losses of hearing and vision, diabetes, cancer, etc.) has been an important development in helping older adults learn new skills, coping patterns, and flexibility. The ability to give as well as to receive assistance is an important characteristic of social support (Ingersoll-Dayton, 2001), which is, in itself, a powerful argument for group participation.

An important perspective in dealing with these losses is recognizing and reinforcing strengths relevant to later life. Wisdom, according to Baltes, Smith, Staudinger, and Sowarka (1990), includes a deep understanding of human nature, knowledge about social relationships, and recognition of life's uncertainties (Ingersoll-Dayton, 2001). Another strength of older adults is resilience, the ability to cope with setbacks and recover. Resilience also implies the ability to reframe cognitively what has happened, changing the meaning of the event (Pearlin & Skaff, 1995) in order to deal with unbearable losses.

Yalom's (1975) classic description of the curative factors of group therapy has been adapted to apply to the aging by Ronch and Crispi (1997), Ranney and Burnside (2005), and others. The following are especially important for group leaders working with older adults to strive to achieve: instillation of hope; universality (learning that others have had similar experiences); a sense of belonging and affiliation; the opportunity to learn and assume new and meaningful roles; receiving and sharing information and skills in problem solving; consensual validation and affirmation; offering a safe place for ventilation and integrating diverse experiences; and encouragement to explore creativity both in the arts and through new ways of thinking about life.

INTERVENTIONS

Group interventions in the following categories are discussed: psychotherapy for older adults; groups for the frail and cognitively impaired; reminiscence and life review; support and self-help groups; participatory arts groups; support, education, and advocacy groups; and caregiver groups.

Psychotherapy for Older Adults

Although the prevalence of major depression among older adults is lower than in adults at midlife and younger, the potential adverse effects of depression, such as suicide, neglect of health, and stress on physical and social functioning, make it a significant issue faced by professionals working with older adults. In a survey done by the Centers for Disease Control and Prevention (CDC; 2010) in 2006–2008, 1.6% of older adults suffered major depression, and a total of 6.8% reported depressive symptoms. These symptoms are often secondary to bereavement, adjustment to physical illness, and other life changes. Rates of depression increase with medical problems to 5–10% in primary care and up to 37% after critical care hospitalizations (Taylor, 2014). Among residents of long-term care institutions and the medically ill, clinical depression is found in about 12–16% of the population, and depressive symptoms affect an additional 20–30% (Blazer, 1998). Other emotional problems seen in practice include anxiety, suspiciousness and agitation, sleeping problems, responses to physical problems, losses, and life changes. Long-standing mental health problems such as schizophrenia and alcohol and drug abuse are also present in older adults. Only about one-fourth of depressed older adults actually are treated for depression. Low-income and minority older adults are even less likely to receive treatment.

The following group interventions treat problems of depression, anxiety, long-standing anger, substance abuse, and bereavement. They utilize structured, manual-based therapies involving cognitive and behavioral strategies that have been effective with younger adults and are now being explored with older adults. Treatment focuses on changing patterns of

thinking, learning new skills, and improving problem-solving abilities. Even though the number of participants is limited in these studies, analysis of outcome measures builds an evidence base for evaluating effectiveness of each approach.

Dialectical Behavior Therapy

Lynch, Morse, Mendelson, and Robins (2003) adapted dialectical behavior therapy (DBT) for use with older adults with depression. They found the following components of standard DBT treatment relevant in treating this population: acceptance of elements of life that cannot be changed (radical acceptance), increased awareness without judgment (mindfulness), attentional control (mindfulness), better tolerance of pain, acting contrary to depressive urges, and increased interpersonal effectiveness. By focusing on maladaptive coping styles and behaviors functionally related to depression, the researchers hoped that these behaviors and coping styles could be modified to decrease the likelihood of future depressive episodes.

Thirty-four people with depression age 60 and over living in the community were randomly assigned to either 28 weeks of standard medication management or medication management in combination with a DBT weekly skills training group plus weekly half-hour individual telephone coaching. Group sessions lasted 2 hours. After the first 14 weeks, the 14 sessions were repeated, so each topic was covered twice. Besides receiving weekly 30-minute telephone contact with the therapist, members could also call their therapist between group sessions if there was a crisis. After the 28 weeks, telephone coaching that reinforced the use of these skills continued every 2 weeks, and then was reduced.

Patients in the DBT group sessions showed significant improvements on self-rated depression scores and adaptive coping. They also were less concerned about being liked and about hurting others' feelings, were better able to say no to requests, and felt less responsible for other people's problems compared with patients receiving medication only. The DBT group members also showed nearly significant improvements in hopeless thoughts, which should reduce their vulnerability to suicide.

Cognitive-Behavioral Therapy

The goals of cognitive-behavioral therapy are to identify and reframe negative, dysfunctional thoughts while increasing and encouraging participation in pleasurable and social activities (Taylor, 2014). Developed in the late 1950s by Aaron Beck (1972), it has become one of the most successful and widely utilized psychotherapies and has proved effective with older adults with depression, as well as stressed caregivers (Gallagher-Thompson & Coon, 2007). As Edwards and Fogler (2001) point out, the emphasis in cognitive therapy on educational methods and concrete techniques for change make it especially acceptable to older adults. Their group, New Ways to Feel Good, appeals to older adults intimidated by the term *cognitive therapy*. Two social workers conduct 10 weekly group sessions with a maximum of 10 members who have DSM-IV diagnoses of depression and/or anxiety. Each group session starts with a brief go-around question (starting with an easy, "Tell us about your favorite book, movie or TV show" to a more meaningful, "What was the core value of your family?"), then a short lecture presenting the basics of cognitive therapy, group discussion of problems, reviewing goals, and homework assignments. Participants describe stressful situations involving relationships, physical problems, losses, and other life changes. As they discuss these issues and use statements that reveal distorted thinking, the therapists ask them to explore whether these thoughts were accurate and suggest alternative, more

accurate thoughts. Rose, for example, was unable to call a friend although she knew the contact would be good for her. When she told the group that she thought her friend was angry at her because she didn't call, a group member replied that her friend might be worried about her. The group gave her a homework assignment to call that week. When Rose reported the following week that she did call and that her friend was relieved to hear from her, the group responded with praise for her effort.

Edwards and Fogler (2001) note that some members responded well to adopting cognitive therapy concepts and that others benefitted from observing other's changing perceptions and were able to consider alternative approaches to their problems. Some members mainly profited from the social support, feeling less alone in their depression. The coauthors report that most participants had improved at the end of the group and that about half of them joined monthly follow-up sessions.

Mindfulness-Based Cognitive Therapy

Mindfulness-based cognitive therapy (MBCT) was developed, according to Foulk and colleagues (2014), by cognitive therapists Segal, Williams, and Teasdale (2002, 2013). They wanted to offer a nonpharmacological group intervention that would prevent relapse in depression and incorporated the mindfulness work of Jon Kabat-Zinn and colleagues. The three essential elements of mindfulness are awareness, experience of the present moment, and acceptance (Germer, 2005, as cited in Foulk et al., 2014).

MBCT was implemented as a pilot project with a quasi-experimental pre-post design to assess changes among 50 older adults with depression and/or anxiety. Five groups were held in a community senior center, led by the same clinical social worker. Members were self-referred or referred by health care providers. The format of the group was based on an MBCT intervention manual (Segal et al., 2013). The program consists of eight weekly group therapy sessions and requires 30–40 minutes of daily practice between sessions. The groups are largely experiential, with some cognitive-behavioral didactic content. Participants practice a variety of mindfulness meditations (the body scan, mindfulness breathing, mindful walking), as well as meditation to cultivate compassion. Group members received two CDs of guided meditation, recorded by the group facilitator, to be used for practicing at home, as well as handouts after each session. A 5-hour, mostly silent, retreat was added between sessions 6 and 7. Members of previous groups were also invited to attend.

It was relatively easy to recruit participants for this intervention, and there was a high rate of completion. The outcome of the pre- and posttest measures indicated that, by the end of the MBCT group, participants were ruminating less frequently, were less anxious and depressed, and experienced fewer sleep problems. Participants were also asked to rate the importance of the program to their recovery from depression on a 10-point scale and asked to explain why they made that selection. A 79-year-old man, Mr. M, with a diagnosis of major depression, had had a successful career before he retired but was now almost blind. He had repeated thoughts of being useless. He initially was skeptical about the group process but gradually became receptive, notably after another group member told him about a famous Buddhist metaphor of two arrows. The first arrow is an event that occurs in an individual's life, and the second arrow is how the individual reacts to the event. Mr. M began thinking of his psychological pain as "the second dart." At the end of the group, he wrote: "I can stop the repetitive thoughts, the second dart, and those that usually follow, and the result is a lighter mood. I have appreciated more acceptance of the way things are, and to be somewhat more compassionate toward myself" (Foulk et al., 2014, p. 510). Facilitating

the MBCT group requires developing competence in this method, and ongoing training is required. However, the popularity of this approach among the general public, including older adults, should encourage further replication of the MBCT model.

Forgiveness Groups

Older adults often carry long-standing and powerful feelings of anger, betrayal, and sadness toward someone who has hurt them. Based on a group forgiveness model developed by Hebl and Enright (1993), Ingersoll-Dayton, Campbell, and Ha (2009) adapted this approach for older adults, conducting two 8-session groups with a total of 20 men and women, ages 57–82. A 4-month follow-up session was included; measures of forgiveness as well as of biopsychosocial functioning were collected before and after the intervention.

Forgiveness, in this model, is not the same as forgetting. It involves deliberately giving up resentment toward the person who hurt you while “fostering the undeserved qualities of beneficence and compassion toward that offender” (Freedman & Enright, 1996, p. 983). Research on forgiveness interventions has shown that those who are able to forgive do better in terms of both emotional and physical health.

These two forgiveness groups were organized around Enright’s four phases of forgiveness. Sessions 1 and 2 focused on exploring anger felt toward the offender; session 3 emphasized making a commitment to forgiveness; sessions 4 and 5 worked on developing compassion for the offender; and sessions 6 through 8 focused on experiencing a release from hurt and resentment while moving toward forgiveness. Before entering the groups, individual interviews were conducted in which participants selected one person who had hurt them. This was not always an easy process, and some people changed the person they thought about forgiving during the group sessions. One person decided she wanted to forgive herself.

During the initial session, participants received a journal that had an outline of all the sessions and space for writing their reactions to their own forgiveness process. At each subsequent session, the leaders asked the group members to read from their journals based on questions about forgiveness that they had received the week before. The leaders were surprised to find that people wanted to read at length from their journals, and time management became an issue. At the end of the first group, participants suggested that the sessions be lengthened from 1½ hours to 2 hours in order to allow more time for journal reading.

Overall evaluations were positive. People liked having a shared focus on the single issue of forgiveness and appreciated the nonjudgmental acceptance of the group leaders and members. The journal questions were also viewed positively. As one person put it, “The questions forced me to uncover feelings I had not thought about for all my adult life.”

Facilitators of forgiveness groups should be prepared to deal with trauma-related symptoms that may surface during the session. They also need to be aware of the ambivalence people may have about choosing one specific person to forgive; some flexibility in changing mid-group might be necessary. Another problem that occurred was the relative difficulty of recruiting older adult members to a forgiveness intervention. Surprisingly, people below the cutoff age of 60 seemed more interested. One 57-year-old person was included, but the issue of recruitment deserves more attention.

Narrative Therapy

Poole, Gardner, Flower, and Cooper (2009) describe a pioneering group for older adults focused on narrative therapy. Their team of social work practitioners and researchers had

experience doing narrative therapy with individuals, usually with younger people. They wanted to develop and research one of the first narrative therapy groups for older adults coping with mental health issues and substance misuse.

The authors state that narrative therapy, as an alternative to traditional therapy, “helps people critically assess their lives, develop empowering life stories and keep the problem, whatever it may be, in its place” (Poole et al., 2009, p. 289). The narrative therapy team adapted the approach taken by Carr (1998) to guide their work. They focused on four tenets: “externalizing the problem, developing alternate stories, building a team of witnesses and thickening the thread” (Poole et al., 2009, p. 290). By observing the eight-session group and also conducting interviews with participants, the research team hoped to explore what was helpful and not helpful about the narrative therapy approach.

The group consisted of 12 older Canadians ranging in age from 55 to 70. Seven were men and five were women. The predominant problems identified by participants were primarily depression and alcohol-related issues. The first session included an introduction to narrative therapy, discussing how to let go of and externalize the problem: “the person is not the problem but the problem is the problem” (Poole et al., 2009, p. 202). In subsequent sessions, participants worked to identify and share alternate life stories that included successes, memories, and accomplishments. In sessions 4 and 5, the therapists discussed the role of witnesses/supporters, both past and present, who could relate to the participant as a person, not a problem. The final sessions reinforced the first three tenets, maintaining the non-problem orientation. It was hoped the participants could view themselves as people with multiple stories, teams of supporters, and tools to fight against the problem.

Participants appreciated having two facilitators, one of whom was an older adult. Some felt it might be better to focus on one issue, either depression or substance abuse, not both. Most found the tenet of externalizing the problem and developing a team of supporters the most beneficial aspects of the approach.

Complicated Grief Therapy

Although older adults experience bereavement frequently, many are able to cope with the loss, often with the support of family and friends, as well as formal support groups such as hospice groups. However, complicated grief (CG), defined as a state of chronic mourning and persistent yearning for the deceased, has been underdiagnosed and often untreated (Supiano & Luptak, 2014). Social isolation of bereaved seniors may result in longer duration of grieving and poorer health and mental health outcomes than with younger adults.

To address this need, Supiano and Luptak (2014) designed a group intervention for people over age 60 who had experienced the death of a significant person 6 months prior to group recruitment. The purpose was to compare the efficacy of a CG therapy group with standard group therapy for people presenting with complicated grief.

The authors used the treatment manual for CG treatment for individuals developed by Shear (2003) and adapted the manual to a 16-week group intervention with no modification of content. Participants were randomized into either the CG group or a 16-week grief support group, modeled on grief support groups conducted in an established program facilitated by clinicians. Sessions in both groups were 120 minutes.

The CG therapy included psychoeducation about grief and CG, guided discussion, and five structured activities: “revisiting the story of the death,” “identifying and working on personal goals,” “inviting an imagined conversation with the deceased,” and “bringing in pictures and memorabilia” (Shear, 2003, p. 845). Participants were taught to assess and

monitor their emotions and, as in other groups, were given homework assignments. Results found that participants in both groups showed improvement in measures of CG but that those in the CG group showed significantly greater improvement, which the authors attribute to the structured activities of the CG group. The team developed a CG group therapy manual that included specific CG treatment with evidence-based group techniques.

An Integrated Therapy Approach

These five examples describe therapists' efforts to develop groups based on a standardized method. Leszcz (1997) proposes a model of integrated group therapy drawing on the theoretical perspectives of the various clinical strategies. Rather than selecting from a single focus on social support, interpersonal skills, coping skills, or distorted cognitions, he believes it is consistent to integrate these various methods, employing therapeutic strategies as opportunities arise in the group. Therapy interventions must always be clearly rooted in patient need and evaluated in an ongoing fashion, collaboratively with the patient (Leszcz, 1997). This approach is integrative, not eclectic, in that all strategies proceed from overarching theoretical perspectives. Another aspect of Leszcz's integration involves the concurrent use of medication. Group members exchange information about medications, sharing anxieties and fears, and responding to side effects.

Other Approaches to Therapy Groups

Other therapeutic approaches that are not manual-based vary from short-term to longer term or ongoing groups. Psychodynamic psychotherapy focuses on resolution of interpersonal conflicts, understanding and acceptance of achievements and disappointments in life, and adaptation to current losses and stressors. This approach seeks to help older adults gain insight into their difficulties and the impact these difficulties have on their relationships and themselves (Haight, 2005). For frail elderly group members, the goal is to help members come to some acceptance of physical limitations, to grieve losses of both relationships and physical functioning, to address fears of dependency, and to repair or optimize personal interactions with others in their lives (Klausner & Alexopoulos, 1999).

A short-term therapy group with Holocaust survivors and second-generation members who were not related is an example of a supportive, psychodynamic approach. The group aimed to integrate the past by focusing on the conflicts of the Holocaust. The survivors felt the support of the second generation, who asked to hear their stories, and the second generation was supported when they could share their angry feelings and have them heard and validated (Erich, 2002). The groups met for 10–12 weekly sessions for 1½ hours each. Common themes for the survivors and second-generation members included separation, mourning of loss, anger, and feelings of inadequacy. These common feelings facilitated empathy, understanding, and identification between the two generations.

Ronch and Crispi (1997) observed that, although task-oriented groups are valuable in nursing homes, discussion-oriented groups provide many benefits for the residents. They present a nonthreatening group therapy environment in which to discuss topics participants are unable to discuss elsewhere. The residents can find commonality of experience and develop more meaningful relationships with other members, creating a buffer for loneliness and isolation.

The orientation of Ronch and Crispi's (1997) groups was interactive, with a here-and-now focus. Residents were referred because staff or family members recognized a

maladaptive behavior syndrome or a diagnosable mental disorder. Ronch and Crispi advocated the importance of focusing on the purpose of the group, as well as their perceived problems. They asked, "Why is this resident experiencing difficulties at this time?" Domains included losses, somatic complaints, personality disorders, issues concerning the resident's autonomy, and perceptions of what is expected of them in this situation. Therapists can question the validity of these expectations and clarify situations in which relations between individuals and staff members are built on inaccurate perceptions. These groups, most of all, provided a safe place to express feelings and individuality, which may not be possible in the public atmosphere of institutional living.

In all methods, effectiveness of group therapy is rooted in the individuals' engagement and interaction within the group and the feeling of success and connection they experience. In all of these interventions, the therapists' attitude of respect, hopefulness, and genuine warmth and empathy is essential. The therapist working with older adults has to be more active than is needed with a younger group to ensure a nonfailure experience and to help members' integration into the group through therapist bridging, reframing, or translating patient verbalizations and behaviors (Lesczc, 1997).

The benefits of group psychotherapy are clear. Interactions between multiple medications make it difficult to manage psychological distress with medications alone. Group therapy is less expensive than individual therapy and is often covered by Medicare and other insurance policies, and being part of a group may reduce the stigma attached to therapy that prevents some older adults from seeking treatment.

Psychoeducational Groups for the Frail and Cognitively Impaired

As diagnosis of dementia becomes more sophisticated, early diagnosis is increasingly common. Cognitive-behavioral interventions and other psychoeducational methods can be of great value to people with early and even middle-stage dementia (Teri & Gallagher-Thompson, 1991).

A psychoeducational group for people with mild cognitive impairment and their significant others had multiple goals: improving the use of memory strategies and aids, enhancing well-being, diminishing feelings of distress and helplessness, acceptance of memory loss, and strengthening the partner relationship (Joosten-Weyn Banningh et al., 2011). Patients and their significant others were recruited from memory clinics in one region in the Netherlands. Participants had to be over age 50, have a diagnosis of mild cognitive impairment (MCI), and have an available significant other who was able to participate. Ten weekly group sessions of 2 hours each were composed of five to eight patients plus the significant others. For the first 90 minutes, the patients and their significant others were in separate groups, each with its own therapist. Both groups explored the same topics and received similar information with homework assignments. For the last 30 minutes of each session, the groups met together and summarized the main issues of that session. The focus was on learning knowledge and skills to adequately cope with MCI symptoms and its progression.

The findings from the quantitative measures were mixed. The patients were able to maintain the positive effects of the intervention with respect to acceptance of the diagnosis up to 8 months after the group ended. But they also reported an increase in feelings of helplessness at the follow-up and a lower quality of life regarding their mental health status. They also rated their cognitive performance as worse compared with the immediate postintervention assessment. This was more than likely due to the progression of their symptoms,

but the authors also felt that ongoing support to boost the effects might be helpful. For the significant others, no differences were found with respect to helplessness (which had been low at the start) and acceptance (which had been high). Sense of competence in the significant others somewhat increased. For the significant others, continued support, focused on coping with the consequences of MCI, is necessary.

Another group model for people with early-stage dementia and their partners was the Memory Club (Zarit, Femia, Watson, Rice-Oeschger, & Kakos, 2004). This was a 10-session group designed for 8–10 dyads. As in the previous group, the dyads met separately and together. The goals included (1) gaining more information about the illness; (2) strengthening the dyad relationships; (3) helping with future planning; (4) enhancing communication with other family members; and (5) building supportive relationships within the group that can buffer the stresses associated with dementia.

A similar psychoeducational and support group format for people with early dementia is currently used by the “Coffee House” (“Memory Café,” 2001). Coffee House meets weekly in a senior center for 5 hours, beginning with structured group discussion in which members cover such issues as the effects of the diagnosis, their memory problems, and their anger about not being able to drive and being “bossed” around by spouses or adult children. Guided by co-leaders, participants are encouraged to openly discuss the losses they are feeling and their anger, fear, and other emotions. It has also become an activist group. Members compile “tip sheets” to advise others how to communicate with someone with memory loss and to discuss how they would like to be treated: “Don’t speak louder. Take your time. Give me time to answer. Don’t say a lot at once.” Several members also appeared on panels at professional meetings to talk openly about their experiences and to tell professionals what they needed from them.

Besides participating in the support group, members exercise, have lunch together, and work on individual projects, such as guided autobiography. Some have compiled memory books or tried painting and other art projects. The objectives are to find ways to maintain the participants’ existing strengths, to help them find productive activities, and to respond to the individual’s entire life history, not just their status as a person with memory loss.

Cognitive stimulation groups (CS) are widely used in the United Kingdom and elsewhere to strengthen cognition and enhance quality of life for people with dementia (Fernandez-Prado, Conlon, Mayan-Santos, & Gandoy-Crego, 2012). A randomized controlled trial of 201 people with dementia in day centers and residential homes compared a 14-session CS group with a control group participating in the usual activities offered in each setting (Spector et al., 2003). Each CS group began with a reality orientation board and a warmup activity such as a softball game, then progressed to themed sessions including reminiscence but also relating the theme to the present. The outcomes showed that participants in CS therapy showed significant improvement in two measures of cognition and also improvement in quality of life.

Written and Oral Reminiscence

Reminiscence as an intervention grew out of the seminal article by Robert Butler (1963) on life review, which he characterized as “a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence of unsolved conflict; simultaneously and normally, these reviewed experiences and conflicts can be surveyed and reintegrated” (Butler, 1963, p. 66). Butler regarded reminiscence, the process of recalling the past, as the means for achieving life review (Gibson

& Burnside, 2005). Recent writers have challenged the idea that life review is a natural process occurring in individuals before death (Wink & Schiff, 2002). Studies have shown that not all older adults want to review their lives or feel the need to do so. Reminiscence groups have become popular in both community and nursing home settings. However, some people prefer not to review the past; others have painful memories that they would rather forget. Participation should always be voluntary. Overall, participants find reminiscence groups enjoyable, enriching, and a good opportunity to share memories with peers.

Oral Reminiscence

The process of reminiscing in a group can restore a sense of self, as individuals talk about events in their lives that have real meaning for them. There are big differences in how this intervention is used. The group leader has to ensure that everyone has a chance to speak, that the group does not become a series of monologues, and that the talking, listening, and sharing is deepening members' engagement with each other. When painful memories surface in the group, individual sessions with the group leader may be necessary in order to fully address the emotions arising from the reminiscence session. LoGerfo (1980–1981) distinguished three types of reminiscence: (1) informative—the sharing of stories; (2) evaluative—similar to a life review process; and (3) obsessive—rumination, repetitive thoughts, obsessive mourning. Experienced leaders need to recognize the obsessive reminiscences and address the needs of the individuals involved without allowing them to dominate the group.

Many reminiscence groups are structured through themes. Gibson and Burnside (2005) report that most themes use a lifespan, chronological order, such as first pet, first job, first day of school. They recommend that leaders be flexible about themes and change them if the group is not interested. Ideally, the group should be involved in selecting themes. The wording for themes should be very precise and easily understood. Gender and cultural aspects of the group need to be taken into account (see Nomura, 2002, for examples of themes used with Japanese older adults). Although a variety of professionals and staff members lead reminiscence groups, the availability of kits and other structured programs can, with an inexperienced leader, result in sterile, rote kinds of groups without significant interaction and engagement among members. Props, including those that stimulate the senses—hearing, taste, smell, and touch—can be effective in eliciting memories: the smell of coffee, the odor of mustard plasters, the feel of a familiar lotion smoothed on hands, the sound of music both long past and current.

One group for healthy older people living in the community used odors as triggers (Hanaoka, Muraki, Yamane, Shimizu, & Okamura, 2011). Twenty-five Japanese older adults participated in eight sessions held twice a week for 90 minutes. Session themes ranged from seasonal celebrations to school events and memories of their home towns. Odors paired with these sessions included incense (Obon, the holiday for remembering those who have died), mosquito coils (summer vacation), and steamed sweet potatoes (festivals). Measures done before and after the intervention showed a significant decrease in depression as measured by the Geriatric Depression Scale (GDS) but no change on well-being measures. The authors believe that further sessions might show more positive outcomes on well-being.

Erwin (1996) and others have designed specific modules for more frail older adults in day centers and nursing homes that use reminiscence selectively and effectively. Using the topic of “favorite vacations,” for example, the group leader begins by talking about her own favorite vacation. As group members identify vacation places they enjoyed, the leader puts

a sticker marking each location on a large map. The leader may prompt questions for sites, smells, sounds, weather, or people who were part of the vacation. Erwin's topics are not only based on the past but incorporate the present, recognizing that reminiscence, though about the past, is actually a present, here-and-now experience (Gibson & Burnside, 2005). Groups for frail older adults often are conducted for an hour each session and may include a time for refreshments and informal conversation. The use of volunteers is also helpful in nursing home groups so that attention can be paid to individual needs, such as hearing problems or restlessness.

An innovative use of reminiscence in a nursing home is the intergenerational group described by Mary Rumman (2001). Daughters participated in the eight-session group along with their mothers. Each session lasted an hour and took place in the late afternoon, which was generally more convenient for the family members. In the first session, all members took part in a name association game and completed the end of a proverb (e.g., "Too many cooks. . ."). In subsequent sessions members reminisced about family members and trips they had taken. They also responded to familiar items in a reminiscence box (baby powder, Hershey's kisses, cinnamon). Mothers sat next to their daughters, who joined in the reminiscing, prompting and adding to their mothers' memories. One especially poignant session involved a "memory gesture," asking members to make a gesture evoking a role important in their lives. Members gestured kneading bread, planting seeds, diapering a child. When one very frail resident almost threw herself out of her wheelchair by demonstrating how she used to serve a tennis ball, her daughter and all the other group members were struck by her strength and could visualize the young, active person she had been. This woman died shortly after the group ended, but the memory of her tennis gesture remained vivid to her daughter. At the final session, the daughters brought in a memento that their mothers had treasured, and together they talked about what these items meant to them both.

Written Reminiscence

Besides the oral reminiscence groups just described, an increasing trend is toward written reminiscence, such as the guided autobiography groups developed by James Birren (Birren & Cochran, 2001). The process of writing stimulates further recall and gives group members a chance to rehearse and edit the memories before they present them to the group. Birren and Cochran (2001) organized group sessions around themes that were more reflective than the themes discussed in oral reminiscence: the major branching points in one's life; one's family; the role of money in one's life; major life work or career; health and body; sexual identity; experiences with and ideas about death, spiritual life, and values; goals and aspirations. They also suggested expanded themes for specific groups, such as war veterans, prospective retirees, and ethnic minorities. The goals of this kind of group include: (1) helping to build a sense of community; (2) developing strategies to deal with life changes; (3) helping group members understand their pasts and also explore future directions; and (4) helping members find resources to face challenges and losses.

Other, less structured writing groups combine both the practices of writing at home and reading in the group, with group discussion about the writings. Chandler and Ray (2002) describe a "senior memories" group with primarily African American seniors. Members gathered to write memories of Detroit, and their writings conveyed a strong sense of place, "the dirt streets, the tired horse and wagon tumbling full of what any household could part with for the money" (Chandler & Ray, 2002, p. 79). They also reflected on their own lives, their childhoods, work, and families. Leaders did not assign topics but prompted as needed.

Participants agreed that they said things in this group that they hadn't told their friends or families (a common finding in writing groups).

Such diverse groups as Hispanic older adults in a New York settlement house, retired seamen, and participants meeting at an African American library are described by the writers, social workers, and artists who facilitated these groups, which were sponsored by a writing project in New York City (Kaminsky, 1984). Written, as opposed to oral, reminiscence has the value of creating a concrete product that can be shared by many others outside the group and that exists as a legacy after the person has died. Writing also bestows a new identity, that of a "writer," to group members, which makes this process more acceptable to many seniors than group therapy or a recreational group.

Most of the writing groups described in this chapter are short term, lasting 8–10 weeks with possible follow-up sessions. The benefit of a long-term writing group continuing more than 20 years is described by Campbell (2001). Men and women from very different backgrounds, educational levels, and beliefs, through their writing, become a kind of surrogate family, sharing intimate stories, helping each other when they are ill, providing food and transportation when needed, and attending memorial services as members die. Although members do write memoirs, they also write fiction, poetry, letters to the editor, and philosophical essays. The group is loosely structured so that the members request assignments as needed from the group leader. However, frequently they respond to what is happening currently in their lives, as well as to memories stimulated by writings of other group members. In a recent group session, Mr. B began with a letter to the editor about politics in Washington; Ms. C wrote about her recent surgery and slow recovery; Ms. D began writing about an argument she had as a child with her cousin over a pet, which led to the revelation by her cousin that Ms. D had been adopted, a fact she had not known before. The readings and discussions form an intricate pattern, going back and forth among past, present, and future. Although this group is led by a social worker, another, similar group has been facilitated by a volunteer for many years. The cohesion and success of many short-term groups offer possibilities for continuation that should be explored.

Writing and reminiscence groups for frail older adults are described by Supiano, Ozminkowski, Campbell, and Lapidus (1987). Volunteers were used to take down the oral compositions of nursing home residents. Many group participants achieved important benefits: reduced depression, improved interactions with other nursing home residents, and a restored sense of identity and achievement. Writings were displayed in several nursing homes, and a collection was published and distributed to friends and family members. The effect on the nursing home staff was also positive, as they observed residents engaged in a very different way than was usually seen on the floor.

Participatory Arts Groups

Arts and creative expression programs nurture talents that may not have been evident in earlier years and are also therapeutic for many participants. Well-known folk artists such as Harry Leiberman have emerged from art classes in senior centers. Worley and Henderson (1995) used creative drama as a means to help older adults integrate their thoughts and dramatize personal narratives. A photography group for seniors not only increased their skills and knowledge of photography but enhanced social relationships among peers and family and brought recognition and admiration for their work (Takahashi, Tokoro, & Hatano, 2011). Aging can liberate individuals from earlier roles or obligations and spur those who always wanted to act or write or paint to do it now before time runs out.

The most exciting area of arts engagement in terms of both research and activity involves art and dementia. Several reviews of the literature (Beard, 2011; de Medeiros & Basting, 2013; Noice, Noice, & Kramer, 2013) provide a fascinating picture of the possibilities of arts activities, including music, art, storytelling, drama, and dance. Noice and colleagues (2013, p. 751) found “overwhelmingly positive cognitive/affective/quality of life outcomes for various participatory art forms.” They all call for more systematic research but advocate an emphasis on the depth of meaning and enrichment that arts activities offer, the power of giving “voice” to the person with dementia. Beard feels that much of the research has focused on reducing behavioral problems and advocates focusing more on the joy of arts participation, preferring the term *arts activities* to *arts therapy*. De Medeiros and Basting, in their review, note that pharmacological interventions, “with the exception of donepezil, showed little positive benefit compared with many psychosocial interventions and music therapies, in particular, which demonstrated effectiveness, at least in the short term” (2014, p. 351).

Notable programs in this area include the project designed by the Museum of Modern Art in New York, called “Meet Me at MoMA.” Groups of people with dementia, along with family and day center staff members, visit the museum and participate in conversations about the art, led by MoMA educators (*MoMA.org*). The museum has provided guidelines for other institutions to replicate this innovative program.

Two interesting programs offer a collaboration between university art students and people with dementia in day center and other community settings. The University of Alabama’s Bringing Art to Life program and the University of Michigan’s Memory, Aging, and Expressive Arts class (*retainingidentity.com*) incorporate the elders’ life stories into the artwork. Students learn about dementia in class, then interact with people with dementia, as well as their families and day center staff. Together they produce art in painting, weaving, metal work, clay, and video. Evaluations from both the older people and the students have been highly enthusiastic, and the work produced is often impressive.

One storytelling program, TimeSlips (TS), created by Anne Basting to encourage creative expression for people with dementia, has been systematically studied in recent articles. Fritsch and colleagues (2009) evaluated the impact of TimeSlips on staff and resident outcomes in nursing homes. TimeSlips was developed for people with middle- to late-stage dementia who have some capacity for communication. It focuses on existing abilities, such as creativity and imagination, rather than the deficits. Groups consisting of 10–12 residents meet once a week for an hour. The facilitators, nursing home staff, ask open-ended questions about an evocative picture they display and record residents’ responses on pads of paper, emphasizing that there are no wrong answers. The facilitators then weave the responses into a story, reading it back to the participants to maintain their focus and enthusiasm. The story is later transcribed and, with the picture, displayed in the residents’ unit. TimeSlips stories are often included in a facility’s newsletter or distributed in books to families. The method differs from reminiscence and memory in that, rather than dealing with past memories, it concentrates on building a story with the imagination. Findings from this controlled study revealed better outcomes among staff and residents in the TS settings as opposed to the control ones. TS increased the number of interactions between residents and staff, as well as the amount and quality of resident engagement.

In another study of 10 residents in a 6-week TS group, George and Houser (2014) identified four specific benefits for residents: increased creativity, improved quality of life, positively altered behavior, and involvement in meaningful activity. The authors also found benefits for staff members and the nursing home community in improving the environment

and the relationships among residents and staff. George, Stuckey, and Whitehead (2014) also studied the involvement of medical students in TimeSlips groups and found an improvement in their attitudes toward persons with dementia and insight into their creativity and potential.

Support, Education, and Advocacy Groups

Support groups help members work through difficult life transitions—illnesses, widowhood, retirement. Often these groups combine an educational purpose with support, as in an 11-week Pathfinders class for recently bereaved widows and widowers (Caserta, Lund, & Rice, 1999), which focuses on increasing competency in self-care skills such as meal planning, household maintenance, and managing finances. The hospice movement has made extensive use of bereavement support groups as an integral part of the grieving process.

There is a large category of health-related groups that combine support with education and specific skill-building tasks to encourage behavior change. Diabetes, arthritis, and other chronic illness groups help older adults to reduce symptoms and have more control over their disease. Kaslyn (1999) discusses the logistics and benefits of telephone conference call support groups as an innovative method of reaching homebound older adults. As more and more older people use the Internet, support online will also be convenient and helpful.

One sometimes overlooked health issue, smoking in older adults, is a major health problem (94% of deaths due to tobacco use occur among people over 50 years of age, of whom more than 68% are 65 or older; Thomas, Supiano, Chasco, McGowan, & Beer, 2009). Thomas and colleagues' (2009) effective model of a smoking cessation group for seniors utilized three components: physical addiction, psychological or learned behaviors, and social factors that keep people smoking. Participants were educated about these three domains prior to quit day. They also instituted a buddy system to combat social isolation and loneliness. After the 7-week group sessions ended, members were strongly encouraged to attend the twice monthly "Stay Quit" maintenance group, where participants continued to interact with other group members, as well as the group facilitators, a tobacco cessation specialist, and a clinical social worker. Other elements of this program were financial assistance with transportation and the provision of nicotine replacement therapy and/or bupropion hydrochloride at no cost for up to 3 months.

In their discussion of outcomes after completing seven groups, Thomas and colleagues (2009) reported a cessation rate across three time periods of 68%. Long-term success rates were enhanced by individual follow-up on nicotine replacement therapy or bupropion hydrochloride, development of alternative behaviors to smoking, and the development of group cohesion and socialization.

Concerning groups for special populations, such as older gays and lesbians, Fassinger (1997) emphasized the importance of going beyond psychological interventions to encompass advocacy, consultation, and attention to social systems. Advocacy groups and political movements, such as the AARP and the Gray Panthers, offer leadership roles to older adults and opportunities to make an impact on society. Retirees make up a substantial proportion of board members of nonprofit organizations and are a significant force in many volunteer groups aimed at social change or helping others, as in meal delivery programs. In volunteer groups such as peer counseling, older adults plan and implement programs to benefit their peers and provide a link between professionals and elderly clients (Bratter & Freeman, 1990; Campbell, 1995).

Other group learning interventions that exist outside the usual group work literature include the Road Scholars program (previously Elderhostel), Osher Lifelong Learning Institutes (OLLI), and the Oasis program, which have responded to the increasing education levels in the older population and their enthusiasm for continued learning and teaching. Classes, often taught by retirees themselves to their peers, cover a wide range of topics, such as languages, literature, politics, and philosophy, and they offer the stimulation of challenging ideas, along with group interaction. Their widespread popularity can be seen in the extensive listing of lectures, study groups, travel programs, and arts activities that appear in program quarterly catalogues such as the University of Michigan OLLI program (www.lli.umich.org). The OLLI programs, starting in 2000 with grants from the Osher Foundation, partnered with universities and colleges to develop lifelong learning programs for people age 50 and over. They are “volunteer-driven,” with the members facilitating study groups, selecting the curricula, and serving as board members to actively steer the direction of the programs. There are now 119 institutes in the United States (osherfoundation.org). Oasis, founded in 1982, provides intellectually stimulating programs in 39 cities throughout the United States, utilizing the skills of many older volunteers (Kerz, Teufel, & Dinman, 2013).

Groups for Family Caregivers

Family members who provide most of the care given to frail older persons can find satisfaction but also stress in caregiving. Many of these informal caregivers, primarily spouses but also adult children, are themselves over the age of 60 and coping with their own aging issues. Because of growing concern with the needs of these caregivers, group work with family caregivers has developed into a major focus of the group work literature for older adults, what Gallagher-Thompson and Coon (2007, p. 37) characterize as an “explosion in scientific research on the experiences of informal caregivers.” Their review of the literature identifies evidence-based psychological treatments (EBTs) for reducing distress and improving well-being of family members caring for an older relative with cognitive and/or physical impairment. Using their framework, three different types of group treatment are discussed in this section: psychoeducational skill-building groups, psychotherapy groups, and multi-component interventions.

Psychoeducational Skill-Building Groups

Psychoeducational interventions are increasingly used to address the problems of caregiving. A general stress mediation model (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995) suggests that multidimensional mediation may be needed to improve outcomes in a stressful situation. Ostwald, Hepburn, Caron, Burns, and Mantell (1999) developed a 14-hour training program of weekly 2-hour sessions for primary caregivers and their families based on this model. At least one additional family member other than the primary caregiver was required to accompany the caregiver and patient to the seven weekly sessions. Patients participated in a concurrent day center program, making it easier for the caregiver to attend the group. The structured content began with information about dementia; in subsequent sessions, caregivers viewed videos of the assessment of their relatives and were told their family members’ functioning levels. The last two sessions focused on caregiving skills, with an emphasis on involving all family members as active learners. An interesting outcome of this program was that improvement on the burden score was not apparent until the 5-month

follow-up interview. Compared with the waiting-list control group, who showed substantial increases in their burden scores during this same period of time, the treatment group on average showed a reduction in feelings of burden, and the treatment also seemed to prevent any significant increases (Ostwald et al., 1999). An updated version of this model, the Savvy Caregiver program, is available online, packaged with manuals for the facilitator and caregivers, CDs and handouts, and caregiver homework assignments.

A new model which has become popular, mindfulness-based stress reduction (MBSR), aims to reduce stress, burden, and depression among caregivers of people with dementia and other chronic illnesses. Whitebird and colleagues (2013) randomly assigned 78 family caregivers to either an MBSR group or a community caregiver education and support intervention (CCES). Each group held eight weekly intervention sessions, including a 5-hour retreat or wellness day, and all members participated in home-based practice. The MBSR participants learned the concepts of mindfulness, practiced meditation, and gentle yoga in each session. They received instruction on sitting and walking meditation, body scan, and yoga and stretching exercises and received CDs and written material to help them practice at home. CCES participants received education on dementia and family caregiving and participated in support group discussions, facilitated by a clinical social worker.

The study confirmed that MBSR was acceptable to caregivers based on recruitment and retention. It also was more effective than CCES at improving overall mental health, reducing stress, and decreasing depression 2 months after the intervention (Whitebird et al., 2013), with both groups showing improvement in anxiety postintervention that was retained after 6 months. Whitebird and colleagues (2011) also have written a comprehensive discussion on recruitment strategies for MBSR groups and clinical studies. Epstein-Lubow, McBee, Darling, Arney, and Miller (2011) used a similar model with positive outcomes, and Hou and colleagues (2014) found that MBSR was effective with caregivers in Hong Kong.

In another skill-building program (Gallagher-Thompson & DeVries, 1994), wives and daughters of individuals with dementia attended “coping with frustration” classes, in which they were taught specific skills, such as relaxing in a stressful situation and learning to be appropriately assertive with their elder and other relatives. The authors feel the strategy of using “classes” instead of “group therapy” reduces the stigma that many people attach to seeking help. Three models of psychoeducational intervention have been developed by Gallagher-Thompson and colleagues (1997): coping with depression, increasing problem-solving skills, and anger management. Caregivers monitored their moods and pleasant events and set step-by-step goals to increase these events. Participants showed decreases in depression and increases in morale when compared with a control group. The problem-solving class focused more on problem-solving strategies for daily life, whereas the anger management class incorporated relaxation techniques and taught participants to identify specific situations that precipitated anger, as well as the physical manifestations of anger (Gallagher-Thompson, Lovett, & Rose, 1991).

All of these classes were attended by European Americans. Gallagher-Thompson and colleagues (1997) adapted the program to make it specifically relevant to Hispanic caregivers of dementia patients. One change was to begin each session with a “check-in” time because the Hispanic caregivers wanted to talk to each other informally before the class began. The leaders also noted that the pace of information was too fast and that the reading materials, translated into Spanish, needed to be modified to be more relevant to the Hispanic situation. A great deal of interaction and peer support arose among the caregivers as a result of the skills training component.

Caregiver Psychotherapy Groups

Shaw (1997) co-led a long-term Alzheimer's Association family support group guided by the modern analytic group principles of paying attention to the resistances brought up in the group process and the transferences to other group members or group leaders. The group had a maximum of 12 members and was culturally, socially, economically, and religiously diverse. Loneliness and loss of companionship were common themes. When one man talked about his 24-hour devotion to nursing his wife, refusing to place her in a nursing home, the leader used a bridging technique to help build emotional connections between him and other group members. The leader asked group members why the man continued in these devoted efforts while depriving himself of pleasure. The group noted his sadness, frustration, and moral conflict. He was able to share his anger and disappointments within the empathic safety of the group.

Akkerman and Ostwald (2004) conducted a 9-week CBT group to address physical, cognitive, and behavioral components associated with caregiver anxiety. The sessions focused on each component over a 3-week period, and participants practiced skills to reduce anxiety related to each of the three components. Gallagher-Thompson and Coon (2007) note that outcomes for this study and for individual CBT interventions show that they are very effective in reducing symptoms of anxiety and depression.

Caregiver Support Groups

Support groups differ from traditional group therapies in that their goal is not to change the members' problematic behaviors but to provide group support and information. They are widespread, inexpensive to run, and can be professionally or peer led, often organized by a local or national group such as the Alzheimer's Association. Although many reports suggest that these groups are effective at relieving caregivers' levels of stress, the majority of controlled experimental studies have not shown that they have any significant effect (Hebert et al., 2003). However, most of the groups studied have used, on the average, eight weekly 2-hour sessions, frequently using information and emotion-sharing strategies. Hebert and colleagues (2003) suggest that these programs need to be spread over a longer period, to have a specific theoretical framework, and to focus especially on the management of difficult behaviors and the responses they create.

The University of Michigan's Turner Geriatric Clinic has two ongoing support groups, as well as a structured six-session lecture/discussion format, which is held two or three times a year. The ongoing groups, one for adult children and another for spouses (Caring for Your Mate), allow caregivers to attend regularly or irregularly, depending on their situation. The groups have a strong nucleus of participants who both receive and give support and information. New members can join at any time; members frequently remain in the group for an extended period of time after the person they were caring for dies.

Two problems with support groups are that they reach a relatively small percentage of those who need help and that they are predominantly composed of white, middle-class, more highly educated individuals. An eight-week series for African American women caring for a parent with dementia (Sistler & Washington, 1999) used the serenity prayer as a major theme of their sessions. Caregivers discussed what factors they could not change, such as their parents having the disease and the progression of the illness. Problem-solving activities focused on difficult behaviors, on identifying feelings of both the caregiver and care receiver, on caring for oneself, and on keeping the care receiver active. Participants discussed

religion, prayer, and their feelings about God. Combining problem solving with the serenity prayer helped participants improve in self-confidence, well-being, and happiness, as measured in posttests. Targeting a specific homogeneous group is effective in reaching caregivers who do not usually attend support groups. This is also true for male caregivers, who often feel more comfortable in men-only groups.

One way of meeting the needs of caregivers who have difficulty attending meetings is by using technology, such as Internet caregiver chat rooms, to provide support and empathy. One busy caregiver said that when she woke up at night and couldn't sleep, she would go on her computer and find companionship among other caregivers in this virtual group.

O'Connell, Crossley, Crammer, and Morgan (2014) developed a secure video-conferenced support group for rural spouse caregivers of individuals with atypical and early-onset dementia in Canada. Ten caregivers agreed to commit to monthly meetings for 90 minutes. The group was facilitated by two psychologists, who structured the group as interactive and collaborative, respecting the members' wishes for emotion processing rather than a psychoeducational group. Caregivers reported it was important to have a group of caregivers who were struggling with similar behavioral changes who could share peer information. Most of these caregivers were middle-aged and appreciated being able to talk to people in their age group. Another study compared telephone support programs for adult children caregivers and spouse caregivers. They had 12 weekly 90-minute group sessions. Results found that the intervention had strong positive effects on the adult children who participated but not on the spouse caregivers, who were generally older than the adult children (Smith & Toseland, 2006). The authors speculate that the spouses might prefer face-to-face contact and the benefits of meeting outside the house.

A *multicomponent model* in an outpatient clinic combined the support-group approach with two individual and four family task-oriented counseling sessions. Spousal caregivers were required to attend weekly support groups, which continued indefinitely. Counselors were always available to help deal with crises and to meet changing needs. As a result, spouses in treatment groups were able to delay nursing home placement almost a year longer than the control group for patients in the early to middle stages of dementia, when placement is probably least appropriate. Originally developed in New York City, this model has also been replicated in Minnesota (Gaugler, Reese, & Mittelman, 2015; Mittelman, Ferris, Shulman, Steinberg, & Levin, 1996).

Because individuals have a wide variety of needs and preferences, it is helpful to have a repertoire of strategies, not a "one-size-fits-all" approach. Clinicians should identify the goals of the group in order to determine which intervention to use. Interventions of seven to nine sessions are adequate to address knowledge and skills but may not provide enough time to improve depression or alleviate burden.

FUTURE DIRECTIONS

The much anticipated baby boom generation is expected to present a new face of aging. In terms of education, income, skill with new technologies, and a greatly increased population of older Hispanics and Asian Americans, the look of future generations is bound to be different. What that will mean for group work can be seen in the success of current examples discussed herein, such as lifelong learning and new ways of working with the cognitively impaired and those who care for them. This generation will also be more accustomed to psychotherapeutic and self-help interventions than the previous generation of older adults,

as evident in the popularity of mindfulness-based groups. Leadership will more often be assumed by older adults, who will have a stronger voice in directing the types of groups and level of professionalism involved.

The rapid growth of adult day centers, assisted living, and continuing care retirement communities creates a new category of group living that presents opportunities for different kinds of group work and exploring new kinds of communities of older adults. Individuals fully accustomed to and comfortable with the computer and the Internet will develop new kinds of virtual groups, which can already be seen among caregivers and people with Parkinson's disease and other chronic illnesses.

As more people live to advanced old age, the profession needs to explore how to work with "individualized" group plans and evaluate which are effective with diverse populations in terms of race, ethnicity, education, and physical and cognitive ability. It is hopeful to observe that many of the interventions described here are being systematically studied, often using control groups, to determine exactly what benefits can be expected from certain interventions. Although many of the interventions described in this chapter focus on just one or two groups and limited numbers of participants, it seems clear that the field has gone beyond mere pre- and posttests of one group to identify what are the benefits and challenges of specific interventions.

The challenge is not only to continue intensive evaluation of group methods but also to develop new ways of collaborating with older adults in clarifying expectations for groups and developing flexible models that can change as the needs of members change. For the generation that brought new meaning to the term *commune*, it will be interesting to see what new forms of groups will emerge to meet the multiplicity of experiences that are part of aging. Perhaps the most difficult challenge is to train practitioners in group work and to integrate groups more completely into senior settings. It is unsettling to look at a large number of activities programs in institutional settings and day center programs and observe a limited range of formulaic activities, such as trivia and bingo, and few opportunities to share feelings, anxieties, and common experiences. As discussed here, many group modalities are being developed and studied. The next step is to train professionals in the field to use them effectively to enhance the quality of life for older adults and their caregivers. And, we may add, to enrich the lives of practitioners through the joy of sharing the group experience with diverse groups of older adults.

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CHAPTER 19

Groups for Reducing Intergroup Conflicts

DAVID BARGAL

In Western democracies, which are characterized by pluralism, various racial, ethnic, and interest groups hold divergent outlooks. Each group pursues its own goals and seeks to gain influence, power, and resources from the available pool of material, social, legal, and political means. Traditionally, such conflicts have been resolved either through violence or through legal action. Although such means may offer immediate solutions to concrete issues, they cannot in themselves achieve long-range settlement of the conflict, nor do they create a climate for ongoing dialogue between the parties in conflict. It is possible, however, to develop conflict management strategies to help the rival parties engage in more open and rational dialogue in order to achieve their goals through negotiation and mutual consent.

This chapter presents the rationale, theoretical background, and intervention principles for conducting workshops to improve relations and reduce conflict between groups. A detailed description of an intervention that I conducted illustrates an attempt to improve intergroup relations between Arab and Jewish youth in Israel and serves as the main source of data. It is argued that social work, and group work in particular, may provide appropriate settings for promoting interventions aimed at improving intergroup relations in many situations encountered by clients. In accordance with this approach, social work with groups should deal more with ethnic, cultural, racial, community, and organizational conflicts and should offer a repertoire of interventions to cope with these issues.

ARAB–JEWISH RELATIONS IN ISRAEL AND CONFLICT MANAGEMENT WORKSHOPS

The Israeli–Palestinian conflict is a protracted one and has recently even escalated to the point of frequent suicide bombings and harsh responses by the Israeli army. About 18% of the population of the State of Israel is composed of Arabs, who identify with many of their

relatives residing in the Palestinian Authority. However, the Arabs residing in Israel are considered full-fledged citizens of the state and are entitled to full legal, social, educational, and welfare privileges. In practice, because of the ongoing conflict between the Arab countries and the State of Israel, its Arab citizens have been subject to discrimination, deprivation of some rights, and isolation from the Jewish population for almost 50 years.

Although behavioral sciences may not have a direct impact on the political process, which affects Israeli–Palestinian relations, it is possible to bring about change among individuals at the level of interpersonal and intergroup relations. One of the interventions that has been developed to improve relations between Arab and Jewish youth who are citizens of Israel is the conflict management workshop (CMW).

Bargal and Bar (1990a) defined the CMW as

organizational arrangements devised to bring together two opposing groups (on ethnic, political, or interpersonal grounds) at a relatively isolated location. Through the use of interpersonal, group, and organizational means, the two parties come to know each other's members closely. Some of the roots and manifestations of the conflict between the groups are brought out into the open, discussed and clarified, in order to enable them to get along more satisfactorily. (p. 5)

INTERGROUP RELATIONS AND INTERGROUP CONFLICTS

A renowned scholar in the field of intergroup conflict, Sherif (1966), defined *intergroup relations* as follows:

Whenever individuals belonging to one group interact collectively or individually with another group or its members in terms of their group identification, we have an instance of intergroup behavior (p. 12).

Tajfel (1982), who contributed significantly to research on intergroup relations, has described intergroup relations as “one of the most difficult and complex knots of problems that we confront in our times” (p. 1).

On the basis of their “ingroup,” individuals may develop stereotypes and prejudices and, as a result, discriminate against members of other groups. Moreover, conflictual intergroup relations may escalate toward violence. Numerous attempts to understand intergroup conflict and discrimination have focused on the following main factors: social-cognitive processes (Fiske & Taylor, 1991; Howard, 2000), personality development (Adorno, Frenkel-Brunswick, Levinson, & Sanford, 1950; Altmeyer, 1998), sociocultural influences (Ashmore & Delboca, 1976), social identity theory (Tajfel & Turner, 1986), and competition for realistic resources (Campbell, 1965; Sherif, 1966).

THEORETICAL APPROACHES AND PRINCIPLES FOR REDUCING INTERGROUP CONFLICTS

Various approaches have been employed to reduce intergroup tension and improve intergroup relations. Levy Paluck and Green (2009) reviewed them in detail and evaluated their effectiveness. We chose to focus here on two means of reducing intergroup tensions: facilitative conditions and conflict management workshops.

Facilitative Conditions

Facilitative conditions are based on Allport's (1954) contact hypothesis. This hypothesis, which was elaborated by Amir (1969), has recently been upheld and reconfirmed empirically (Pettigrew, 1998; Pettigrew & Tropp, 2000). According to this approach, the following conditions may strongly contribute toward the improvement of intergroup relations between adversarial groups (Fisher, 1990):

1. Contact in an intimate, pleasant, and rewarding organizational climate.
2. Equal status between the two groups.
3. The existence of cooperative superordinate goals (Sherif, 1958), which participants in the two groups work together to accomplish.
4. Strong institutional support for the program.

Conflict Management Workshops

The conflict management approach derives its principles of intervention from several sources:

1. The notion of reeducation (Lewin, 1945/1948), or resocialization, which suggests that individuals may undergo changes in knowledge, values, and standards, emotional attachments, and conduct mainly through *interaction in small groups* (Lieberman, 1980, 1983).
2. The course of change that occurs among participants in the group is characterized by three phases: "unfreezing," "movement," and "refreezing." *Unfreezing* is the phase in which the motivation and readiness for the change are emphasized. *Movement* refers to the phase in which the participants gradually change their attitudes and reframe their cognitive beliefs toward their own group and toward outgroup members. *Refreezing* refers to the institutionalization of the change in the form of new habitual attitudes or behavior to be applied within, as well as beyond, the group's meetings (Lewin, 1947/1958).
3. The facilitators of the group are the most important agents of change that help participants modify their attitudes, emotions, and behavior. The facilitators employ basic counseling skills such as positive regard, empathy, and support for the participants (Carkhuff, 1969; Egan, 1986), who may engage in a prejudiced discourse in the group sessions. In this context, the facilitators convey the message that the encounter is a safe setting in which participants can renounce biased beliefs about members of other ethnic and social groups. The facilitators also give minilectures concerning issues related to prejudice, stereotypes, group processes, and intergroup conflicts. The lectures are intended to help the participants understand and incorporate the changes, which they undergo more fully (a detailed example of the facilitator's activities is provided later in this chapter). According to Bargal and Bar (1994), the optimal encounter focuses on three main target units: the individual, the small group and its dynamics, and intergroup relations. Following is a general description of each of the three target units.

The Individual Participant's Personality

The participant's personality is at the center of the intervention. The components of the participant's personality include cognitive mechanisms for organizing his or her impression of the social world, such as stereotypes regarding members of the other group and feelings

toward them. Specifically, the intervention focuses on prejudiced and discriminatory behavior manifested by participants toward each other. The principal psychological processes by which stereotypes and prejudice can be modified are: creation of a supportive climate by the facilitators; catharsis of feelings when needed; and planned confrontations regarding participants' biased perceptions of others or themselves. The facilitators are in charge of developing intimate and meaningful contacts among members of the group, in addition to encouraging discussions about beliefs and feelings and enhancing participants' insight into biased attitudes and feelings they hold toward themselves and others.

The Individual Group Member and Group Affiliations

The second target of intervention is at the group level. At the center are the participants' multiple group affiliations, which generate multiple identities. As mentioned, the participants' ingroups are perceived in positive, differentiated terms, whereas outgroups are perceived in a negative, generalized way. The group achieves its goal of molding participants to its standards and norms by exerting pressure (Tajfel & Turner, 1986). The participants are sensitized to these mechanisms as a first step toward alleviating these pressures and developing a more individualistic, independent perspective toward their group affiliations and identities.

Intergroup Relations in a Diverse, Pluralistic Society

The third target of intervention focuses on the intergroup level and on relations among ethnic, gender, and social groups in a pluralistic society. Topics dealt with in minilectures, discussions, and experiential activities focus on issues of inequality and injustice in the relations between the majority group (Jews) and the minority group (Arabs). Common behavioral manifestations of minority–majority relations, such as respect, patronage, and exploitation, are examined. Participants become aware of the need to play an active role as agents of change and point to ways in which they can mitigate social injustice. In this spirit, cooperative projects continue even beyond the duration of the workshop. The projects generally focus on educational and social activities, which are conducted in schools and surrounding communities.

Conflict management workshops have been conducted in an attempt to deal with international conflicts (Burton, 1969), including tensions in Ireland (Doob, 1970; Doob & Foltz, 1973) and in the Middle East (Cohen & Azar, 1981; Cohen, Kelman, Miller, & Smith, 1977; Kelman & Cohen, 1979, 1986). These workshops are based on principles and methods derived from small-group research, as well as from research on attitude change and counseling. Since Lewin first proposed this approach toward managing intergroup conflict (Lippitt, 1949), several modifications have been introduced. Blake, Mouton, and Sloma (1965) and Blake and Mouton (1984) offer a model that entails working with parties in conflict on their images of each other, as well as opening avenues of communication, and working together on solutions to specific problems.

CONFLICT MANAGEMENT WORKSHOPS AT THE NEVE SHALOM SCHOOL FOR PEACE

The Jewish–Arab village of Neve Shalom (“Oasis of Peace”) was founded in 1970 to encourage and enhance meaningful and enduring contact between Jews and Arabs in Israel. The

village is a model of Arab–Jewish cooperation based on equality and mutual trust. Residents live and work together for the attainment of mutual “superordinate” goals within a fully integrated community. Members of each national group are encouraged to maintain and take pride in their separate religious, cultural, and national identities (see Shipler, 1986).

The School for Peace at Neve Shalom is an educational entity that is located in the village but operates autonomously. The school conducts conflict management workshops aimed at promoting peaceful Arab–Jewish coexistence based on equality, mutual trust, and respect. Since its establishment, numerous workshops have been held for Arab and Jewish youth, with a total of 5,000 participants of both nationalities over the years. Although the majority of young people participated in a single workshop, some of them attended several additional meetings as well.

The workshops were held in a “cultural island” (the village of Neve Shalom), where cooperation between the two national groups is put into practice. Several aspects of the workshop have been dealt with in earlier publications (on the role problems of facilitators, see Bargal & Bar, 1990a; on preparation of participants, see Bargal & Bar, 1990b; on the application of Lewinian theory in the workshops, see Bargal & Bar, 1992).

The workshop model applied at Neve Shalom incorporates many of the structural principles of management, training, and evaluation proposed for conflict management workshops (Bargal, 1992). Details regarding the structure, process, and intervention principles that may be generalized and adapted to different cultural settings are presented next.

Components of the Conflict Management Workshops

Objectives

As suggested by Bargal and Bar (1990b), the workshops aimed to achieve the following objectives: (1) to initiate contacts and acquaintances among participants belonging to the two national (Arab and Jewish) groups; (2) to arouse awareness of the complexity of the Arab–Jewish conflict situation; (3) to change previous distorted stereotypes and prejudices that the members of the two national groups hold toward each other; (4) to help participants develop impartial behavior and attitudes toward one another; (5) to teach basic skills for conflict management; (6) to help participants develop humanistic, democratic perspectives and an orientation toward working for social justice.

The detailed description of the encounter between Palestinian and Israeli youths gives an idea of how these objectives were realized. In a subsequent part of the chapter, the process of intervention in the workshop unfolds, and the intrapsychic, interpersonal, and intergroup mechanisms that operated are described and explained.

Selection of Participants

The selection of the appropriate participants for the workshops may largely determine the extent of their success. Research into group work emphasizes the importance of prior selection of candidates for group interventions in order to attain attitudinal change and symptom reduction (on social work with groups, see Sundel, Glasser, Sarri, & Vinter, 1985; Toseland & Rivas, 1984; on group psychotherapy, see Melnick & Woods, 1976; Moreland, Levine, & Wingert, 1996; Yalom, 1985).

The groups of Jewish and Arab youths who took part in the workshops were paired in terms of socioeconomic background in order to promote maximum symmetry between

them (Allport, 1954; Amir, 1969). Moreover, the participants in both groups resided in close geographical proximity to each other, in order to enable continued interaction between them after the workshop ended.

Based on theory, research, and professional experience, it was decided to select participants on the basis of three qualities: (1) high motivation to take part in the conflict management workshops, which is a prerequisite for many change-oriented activities (Egan, 1986; Lieberman, 1983; Yalom, 1985); (2) empathy with and sensitivity to others (the ability to enter the “other person’s shoes”), a prerequisite for encounters that involve changing negative stereotypes and identifying with the other’s sorrow, humiliation, and injustice (Stephan & Finlay, 2000); (3) leadership qualities, for example, “gatekeepers” (Lewin, 1947/1958) or influential members of the class or community. Influential people may disseminate the messages of the workshops to their groups and communities of origin.

Preparation of Participants

In order to enhance the impact of the workshops on the participants, preworkshop anticipatory programs were designed for each national group. In these programs, the groups met separately on their own grounds, and sessions were led by the prospective facilitator or facilitators from the same national group (for a detailed discussion of the preworkshop preparations, see Bargal & Bar, 1990b). The preliminary meetings aimed to provide the potential participants with three elements: basic information on the workshop setting, increased cognitive awareness, and emotional preparation.

The information provided at the preworkshop program included a general orientation to the schedule, activities, and accommodations at the School for Peace. At the cognitive level, the prospective participants in the preparatory phase were expected to heighten their awareness regarding the importance of tolerance toward different attitudes and values to be exercised at the workshop. An additional issue emphasized in the preparatory sessions concerned the deep cultural differences between the groups who would be meeting under very intimate conditions. Notably, Arab society—be it Christian or Muslim—was alien to the Jewish participants. For the Arab participants, who had never met with Jewish youths on close terms before, the open interpersonal relationships—especially between boys and girls—and the spontaneous expression of feelings were often strange and even threatening. The third type of knowledge focused on differential “emotional inoculation” of the two national groups. The Jewish participants had to be emotionally prepared to overcome their fear of Arabs, which is rooted in the persistent threat of annihilation by the surrounding Arab countries. The Arab participants had to be reassured that in the workshop they would be able to disclose their personal experiences of humiliation and rejection by members of the Jewish majority.

These three dimensions of preparation prior to the workshop enhanced the change processes among participants in the actual encounter.

Change Processes That Affect Participants’ Attitudes, Perceptions, and Behavior

The mechanisms for effecting change during the workshop focused primarily on the emotional and cognitive dimensions, such as exposing participants to new sources of information, allowing them to reflect on the sociocultural and political contexts in which they live and interact, and enabling them to restructure their social perceptions (Babad, Birnbaum, &

Benne, 1983; Lewin, 1945/1948; Lieberman, 1983). This section focuses on analysis of the processes of change that occurred during the workshop in four areas: participants, facilitators, workshop structure, and content topics (Bar & Bargal, 1995).

PARTICIPANTS

The main cognitive and emotional mechanisms that operated in the intervention processes were cognitive dissonance; decategorization; limiting the use of denial, splitting, and projection as defense mechanisms; and anxiety aroused as a consequence of fading illusions (Schein, 1979).

Participants in the conflict management workshops described a change in attitudes resulting from cognitive dissonance (Bargal & Bar, 1992; Maoz, 2000). This dissonance was reflected in the discrepancy between their perceptions of the other group and the actual behavior of participants in that group with whom they interacted intensively. The process of attitude change has been referred to as *decategorization* or *destereotyping* (Brewer & Brown, 1998; Lewin, 1945/1948). In this process, negative characteristics attributed to the other national group based on ascription of collective attributes and stereotypes were gradually replaced by new impressions that developed as a result of personal acquaintance with individuals in the other group.

This suggests that stereotypes may ultimately be undermined as a result of favorable personal experiences with members of the other group. However, changes in cognitive perceptions are not immediately incorporated into the psyche. Feelings of frustration may be aroused by awareness of the need to alter distorted perspectives and develop new perceptions of oneself. In addition, feelings of anxiety may be aroused by fear of restructuring cognitive and emotional frames of mind embedded in each individual, for example, perceptions of oneself as inherently bad, irrational, violent, and uncompromising. At this point, the reality personified by individuals in the other group may clash with the mechanisms of denial and splitting that participants have employed all of their lives. Notably, the anxiety and fear associated with giving up the use of these mechanisms may cause participants to express intense anger and to blame members of the other group for the political situation.

This emotionally charged and dissonant situation also provides the “building blocks” for restructuring participants’ new social perceptions. The educational tools for facilitating this situation are group and intergroup dynamics created through the facilitators’ interventions, as well as themes focusing on development of perceptions and skills conducive to “living with conflict” (Bar & Bargal, 1995; Bargal & Bar, 1994). Two important interpersonal processes facilitate changes in self-perceptions and perceptions of the other group: identification with participants from the other group and identification with facilitators of both nationalities.

FACILITATORS

The workshop facilitators bore most of the responsibility for effecting change. In short, during this phase of the workshop, it is very important for participants to experience group and interpersonal dynamics that facilitate change processes. These dynamics are largely affected by the facilitators’ style and the nature of the intervention, which are instrumental in creating these conditions.

In the intervention process, the facilitators make it possible for participants to express some of their disappointments, frustrations, and anxieties through catharsis. The facilitators

employ basic counseling principles such as positive regard, empathy, and support for participants (Carkhuff, 1969; Egan, 1986) in the encounters. In so doing, they convey the message that the encounter is safe enough to enable participants to reassess previous beliefs and express feelings and opinions that they had never dared express before. Although these principles are a *sine qua non* for efforts to change attitudes and behavior, and although provision of support and security may be effective and even vital conditions, they are not sufficient to effect change. Facilitators must focus on utilizing skills that help participants deal with contradictory views and feelings toward themselves or other group members. This is done via the use of confrontational means utilized by the facilitators (Egan, 1986). Such confrontations help participants achieve the cognitive dissonance described previously. Facilitators also provide feedback to participants who express feelings and behavior that can help counteract prejudiced and unrealistic views of their own group or members of the other group. Moreover, facilitators are in a position to provide alternatives to violence as a means of solving controversial political or ideological issues.

At this stage, facilitators also use a strategy referred to by Yalom (1985) as “instillation of hope.” The intensity of the conflictual situation may encourage participants to adopt a fatalistic, pessimistic approach, which signals passiveness and withdrawal from coping with the object of their relationships. Thus facilitators aim to preserve a group climate that portrays the difficult, complex reality of the conflict between the two nations on the one hand and opens a window of hope on the other. Because people create the conflict, there is hope that people may also find a way to solve it.

Another strategy at the facilitators’ disposal is cognitive reframing. Every change in oneself, even in the emotional sphere, is transformed into a cognitive framework of human consciousness. Words, concepts, rationales, attitudes, and values reflect various perceptual and cognitive “gestalts” that are elaborated and adopted by the self. Hence, the facilitator’s function in this phase is to explain and clarify the meanings of the changes within the group from a “here and now” time perspective (Egan, 1986). This is done without ignoring their implications for the external social-political and cultural reality of the participants’ lives.

Finally, the facilitator’s task is to contain difficult feelings expressed by the participants, especially anger and anxiety. The facilitator clarifies that the participants’ feelings at this stage reflect an imbalance in their perceptual and emotional orientation, which is a prerequisite for change. Facilitators also provide information and explanations regarding the intra- and intergroup processes experienced by participants, for example, pressure to conform to the norms of one’s group and demonization of the other group. Moreover, participants gain insight into the group and intergroup dynamics that they experience in the workshops and in the real world. In addition, they become more aware of their impact on shaping behavior and attitudes (Bargal & Bar, 1994).

WORKSHOP STRUCTURE

Work in a relatively large binational group creates a paradoxical situation. On the one hand, an atmosphere of cohesiveness and solidarity is formed as a result of the intensive interpersonal relationships and close contact that develop under the conditions of an isolated “cultural island.” On the other hand, the topics discussed and the constant feeling that one’s own national group is right and good and that the other group is bad generate an atmosphere of anxiety and disharmony among the group members. Even under these circumstances, however, each participant can still identify with the pain, injustice, fear, and

other intense personal emotions genuinely conveyed by members of the other group. This identification helps break down the “walls of hate” and counteract stereotyped categorization while enabling participants to see the other side’s point of view. Concurrently, activity among homogeneous national groups, in which participants are able to share the feelings of anxiety aroused by cognitive dissonance, help them incorporate identification with the other group into themselves. In this process, participants begin to understand their need to preserve their own social and national identity, bearing in mind the emotional cost of ignoring the other group’s identity.

An additional change mechanism at the disposal of participants at this stage of the workshop is identification with the facilitators. In particular, participants can identify with facilitators of the same national group as models who have managed to find a balanced way of living with the contradictory contexts of Arab and Jewish society (Bargal & Bar, 1990a).

In this connection, facilitators are viewed as individuals who have managed to adopt a complex perspective of the situation while remaining confident enough of their own social identities to be able to understand the other side’s point of view. In many respects, the workshop participants aspire to achieve this state, especially when they feel somewhat confused and threatened and need a model to help them implement the desired change. Mature interpersonal relationships between Arab and Jewish facilitators, which are based on consideration and sensitivity, also serve as models for workshop participants to emulate.

CONTENT TOPICS

One of the main contributions of the facilitators was inculcation of the concept of “living with conflict” (Bar & Bargal, 1995). At this stage, the participants experienced the meaning of living with conflict in their interactions—a conflict that emanates from the respective identities of each group. In this phase, the facilitators provide information regarding majority–minority relations while portraying the asymmetry between the two groups and its implications for political processes. Minority groups are often underrepresented and deprived of privileges granted to the majority group (e.g., Jewish Israelis receive a monetary allowance after completion of compulsory army service, but Arab citizens of Israel are not entitled to this compensation because they do not serve in the army).

Facilitators point out the similarities, as well as the differences, between the two groups. They emphasize the overall need for national group identity and the importance of each group’s unique history. In this connection, it is noted that both groups have suffered traumas and disasters (e.g., Jewish participants are affected by the memory of the Holocaust, and many Arab participants have relatives who were exiled following the War of Independence). These examples serve to highlight similarities in the concerns and aspirations of each national group. The dialogue that ensues among the participants also exposes different political solutions to the conflict proposed by each group. The main strategy for coping with the conflict is acknowledgment of each party’s right to autonomous existence. In the case of Israeli Arabs, emphasis is placed on acknowledgment of their full rights and acceptance as equals by the Jewish majority.

At this stage, it is assumed that participants are able to integrate the new perspectives they have incorporated and to practice the new behavior or express the reframed attitudes in real-life situations (Lewin, 1947; Schein, 1979). In accordance with the aforementioned objectives of the workshop, at the end of the process participants are expected to better understand themselves and to realize the complexity of the social-political situation (i.e., that there are no clear-cut solutions to the Arab–Israeli conflict).

Evaluation and Operational Recommendations

According to the participants' verbal reports, as well as the results of the questionnaires (Bargal, 2000; Bargal & Bar, 1992; Maoz, 2000), it seems that the participants benefitted from the workshops on the whole. However, because workshops are short-term interventions, they cannot be expected to bring about significant change in all participants. It is even more presumptuous to think that at this stage most participants are able to integrate the content of the workshops and reframe their cognitive and social perceptions. In fact, some may not realize the impact of the workshop until later, and others may revert to their original attitudes toward the other national group and the Arab–Israeli conflict. In order to examine these questions, it would be worthwhile to conduct follow-up studies, which are very rare in the literature because of their complexity and the high costs involved in their implementation (Stephan & Stephan, 2001).

From our own observations, it is evident that a one-time conflict management workshop will not suffice to effect meaningful change in the participants. In the policy conclusions of earlier studies (Bar & Bargal, 1995), several workshop models are recommended. Based on the experience gained from these workshops, the most effective model is a three-phase workshop sequence. According to this model, participants meet in homogenous national groups in the first phase. These sessions focus on anticipatory socialization—that is, airing fears, conveying information about the intergroup encounter, and developing realistic expectations, emotional resilience, cognitive openness, and tolerance toward the other group. In the second phase, sessions are held in a mixed group, based on the format of the intergroup encounter described here. In the third phase of the model workshop, which takes place at some point after the intergroup encounter, participants meet again in homogenous national groups in order to reintegrate what they learned during the intergroup phase in a more secure group atmosphere.

An additional intervention with a potential long-term impact is a cooperative effort to pursue superordinate goals, such as working on mutual community development projects. The design of long-range cooperative projects devoted to issues that concern both groups may strengthen the bonds created during the workshop. Such cooperation may also help preserve the changes in the participants' cognitive beliefs and social identities that occurred during the workshop. Furthermore, the cooperative effort may ensure that workshop participants selected on the basis of their ability to serve as gatekeepers will succeed in disseminating the messages of tolerance, antidiscrimination, and humaneness as they interact with classmates who did not take part in the workshop.

INTERGROUP INTERVENTION IN SCHOOL COMMUNITIES: AN ACTION RESEARCH STUDY

Following the theoretical principles for intervention cited above, an action research project aimed at reducing intergroup tensions and prejudice was conducted at two high schools in Michigan for almost 10 years (Garvin & Bargal, 2008). The target groups selected for the intervention were 10th graders, who participated in dialogue groups held throughout the school year. The project was approved by school authorities, and the schools were allocated a budget to finance the group activities and the teachers involved in facilitating the groups. The intervention was carefully planned by a policy committee consisting of the principals, teachers, and students at the school. It was monitored by social workers, who collected data to evaluate the effectiveness of the project. The measures for evaluation included

questionnaires, observations, and detailed journals kept by the participants. Evaluations that were conducted on the basis of these measures (Spencer, Brown, Griffin, & Abdullah, 2008) indicate that the intervention had an impact on the systems of the two high schools that went far beyond exposing the participants to educational content dealing with intergroup conflicts and conflict management.

FUTURE DIRECTIONS

Intergroup conflicts dominate the scene in Western democratic societies. As suggested in the literature review, these conflicts emanate from personality and cognitive distortions, which breed stereotypes and prejudice (Adorno et al., 1950; Altmeyer, 1998; Brewer & Brown, 1998). They are the consequence of rigid and extreme perpetuation of ethnic and racial boundaries and may also be generated by ideological and political dissension regarding allocation of resources and feelings of injustice (Ashmore & Delboca, 1976; Campbell, 1965; Sherif, 1966).

The attainment of justice in multicultural and heterogeneous societies depends largely on the ability of ethnic, racial, gender, and interest groups to obtain resources and exercise their rights through democratic means. Notably, pluralistic societies are fraught with conflicts that must be resolved through legal means or through strategies of conflict management. Toward this end, conflict management workshops and intergroup dialogues (Schoem & Hurtado, 2001) have been used to deal with some cases of dissension between groups, such as community conflicts, intergroup conflicts in educational settings (Stephan, 1999), and even parties at war (Kelman, 1997). The groups in conflict, as shown in this presentation of a conflict management workshop for Arab and Jewish youths, have several characteristics. They consist of a small number of participants and can thus develop intimate relationships among their members. During the meetings, the focus of the discussions is on the distorted and prejudiced images each party holds regarding the other and on ways of guiding social institutions toward the pursuit of equality and justice. Individual group members are perceived as representatives of different ethnic and social groups. Therefore, the changes they experience on a personal level may project to the intergroup realm as well.

Group work as a method of intervention in social work was historically involved in education for democracy and intervening in community problems. However, it seems that the present concern of the field is confined to intragroup structures and processes and focusing on interpersonal and intrapsychic problems.

The approach presented here offers an important repertoire of interventions in social work with groups that may also be applied in the American context, which is characterized by prevalent racial, ethnic, gender, and ideological conflicts (for a detailed presentation of the framework, see Bargal & Bar, 1994). Notably, the intervention principles presented here (Allport, 1954; Fisher, 1990; Pettigrew, 1998; Stephan & Stephan, 2001), as well as my own professional experience conducting workshops (Bargal & Bar, 1990a, 1990b, 1992, 1994), may provide a solid base of knowledge that can be adopted by scholars and practitioners who deal with social work in group settings.

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CHAPTER 20

Group Interventions for Partner Abuse

DANIEL G. SAUNDERS

Partner abuse is a serious and widespread social, health, and mental health problem in the United States and around the world (Black et al., 2011; Howarth & Feder, 2013). In addition to the severe health and mental health impacts on victims, children in these families suffer short- and long-term emotional and behavioral effects (Evans, Davies, & DiLillo, 2008). Unfortunately, interventions for partner abuse offenders are plagued by high attrition rates due to their low motivation. Even when treatment is completed, we lack clear evidence to show which methods are most effective, or whether any method is effective. This chapter describes the major group work models in use today, as well as methods used to enhance motivation and to respond with cultural sensitivity. The term *partner abuse* is used here in place of older terms such as *domestic violence* and *wife battering*. Unlike the older terms, *partner abuse* includes dating and cohabiting couples, in addition to married couples, and *abuse* includes verbal and sexual aggression in addition to physical abuse.

There are now more than 2,500 abuser interventions programs in the United States (Cannon, Hamel, Buttell, & Ferreira, 2016; Price & Rosenbaum, 2007). Programs have historically been operated by profeminist men's centers, traditional social service agencies, or battered women's shelters (Bennett & Williams, 2001; Gondolf, 2002; Mederos, 2002). Increasingly, programs are affiliated with probation departments and courts or located in prisons and jails. Most programs are freestanding and not part of a "parent" organization (Dalton, 2007). About 15%-20% are part of a shelter program (Cannon et al., 2016). In other countries, parent agencies are most likely victim advocacy or psychological counseling programs (Rothman, Butchart, & Cerda, 2003).

Group formats are by far the most common form of intervention for treating partner abuse (Pirog-Good & Stets-Kealey, 1985; Price & Rosenbaum, 2007). Group treatment is normally for male offenders but can be for female offenders and couples as well. Most interventions are devoted to stopping men's violence rather than women's, in part because studies show men offend at higher rates (e.g., 20% of women and 7% of men reporting lifetime victimization; Tjaden & Thoennes, 2000). However, the extent of men's victimization continues to be debated.

Regardless, practitioners have increasingly focused on group treatment of women arrested for partner abuse, and several group curricula are available (e.g., Larance, Cape, & Garvin, 2012; Larance, Hoffman-Ruzicka, & Shivas, 2009; Wexler, 2016). Many of these women are also victims of abuse, and they need many services commonly provided for battered women. For this reason, female and male offenders are rarely treated in the same group.

As in most group work, group formats for partner abusers appear to have several advantages. For example, they decrease group members' sense of isolation and increase social support. Studies show that groups that focus on behavioral rehearsal provide an opportunity for realistic role-plays. The group format is essential when groups rely heavily on peer feedback and confrontation. Groups are also more efficient than individual counseling. However, concerns have recently been raised that a group format may produce negative outcomes. Men may reinforce each other's negative views of women and support each other's pro-violence attitudes (Murphy & Meis, 2008). Some practitioners also point to the variations among abusers and that an individualized approach can tailor treatment for more effective outcomes (Murphy & Eckhardt, 2005).

Programs tend to be labeled by their major theories, but these labels do not reflect the rich blending of orientations and methods that exist (Cannon, Hamel, Buttell & Ferreira, 2016). The "smorgasbord" of approaches usually proceeds through three main phases: (1) expanding the definition of "abuse" beyond physical abuse (e.g., Howarth & Feder, 2013), (2) helping members accept more responsibility for their behavior, and (3) teaching members reactions and behaviors that can take the place of aggression (Gondolf, 1997). Many programs are considered "psychoeducational" or "didactic/confrontational." Most combine court-referred and non-court-referred offenders in the same groups.

In one U.S. survey, 53% of programs labeled themselves a "Duluth" model (explained below), 49% cognitive-behavioral, 26% "therapeutic," 14% EMERGE (a specific program in Boston), and 13% "Other" (Price & Rosenbaum, 2007). In a more recent survey, 46% of the programs reportedly used the "Duluth" model's focus on power and control as the primary or secondary focus, with 54% using cognitive-behavioral methods (Cannon et al., 2016). In a survey of programs around the world, the topics covered in decreasing order of frequency were: masculinity, healthy relationships, conflict resolution, cultural traditions, anger management, fatherhood skills, criminal sanctions, substance abuse, childhood trauma, and stress (Rothman et al., 2003).

Intervention methods can also be classified along several dimensions based on their underlying assumptions (Saunders, 1996; for other categorizations, see Aldarondo, 2002; Healey, Smith, & O'Sullivan, 1998; Mackay, Gibson, Lam, & Beecham, 2015):

- *Skills training.* This method is based on social learning assumptions about the behavioral deficits and behavioral excesses of offenders (Stordeur & Stille, 1989). Group leaders model positive behaviors through role plays, followed by the role-play rehearsal of new behaviors by group members. The goal is to enhance relationship skills in order to replace abusive and other negative behaviors.

- *Cognitive restructuring.* This approach assumes that faulty patterns of thinking lead to negative emotions, which in turn lead to abusive behavior (Eckhardt & Shram, 2009; Wexler, 2013). Restructuring of these thoughts is likely to reduce anger and the fear and hurt that often underlie it. More broadly, these approaches can also help men become aware of belief systems developed in childhood, including beliefs about gender roles and male entitlement.

- *Sex role resocialization.* The focus here is on helping men consider gender equality and greater flexibility in gender roles (Stordeur & Stille, 1989). Male dominance is viewed as the result of rigid socialization into the male role.

- *Awareness of control tactics.* These methods build awareness of control tactics used to gain or maintain dominance over one's partner and are represented by the "Duluth model" (discussed subsequently; Pence & Paymar, 1993). The meaning of domestic violence is expanded to include many forms of abuse: isolation, demeaning language, control of finances, and other means of control. The need for power and control is seen as the underlying motive for these forms of abuse. The impact of the abuse on the victims is also emphasized.

- *Family systems.* A family systems perspective can be applied to men's and couple's group work through the analysis of family dynamics and communication patterns and by bringing new insights and skills to the men in the group. There is no single set of assumptions underlying these approaches, but a frequent assumption is that couples unwittingly engage in repeated cycles of interaction that may culminate in abuse (e.g., Stith, McCollum, & Rosen, 2011).

- *Trauma therapy.* This approach rests on the assumption that the men need to resolve their childhood traumas, in particular from witnessing parental violence and being physically abused by parents, in order to increase empathy toward others (Browne, Saunders, & Staecker, 1997). As the healing occurs, the need for controlling others is assumed to decrease.

The first four approaches are commonly integrated into the same program (e.g., Ganley, 1989; Gondolf, 2004; Rosenbaum & Leisring, 2001). For example, the EMERGE program (EMERGE, 2000) combines awareness of abusive behaviors with cognitive restructuring. Narrative therapy approaches in particular blend an emphasis on accountability for healing childhood and social traumas with accountability to society and one's current family (Augusta-Scott, 2009; Jenkins, 2009). The widespread and influential Duluth model—named after the city in which it was developed—emphasizes awareness of violent and nonviolent control tactics and, to a lesser extent, the learning of new skills (Pence & Paymar, 1993).

Family systems approaches are the most controversial. Critics charge that this approach explicitly or implicitly holds the victim responsible for the abuse. Program standards in many states restrict the use of couples treatment, especially if they are used exclusively. Before giving some examples of these methods, I describe some individual and group methods for enhancing group attendance.

MOTIVATORS FOR GROUP ATTENDANCE

Criminal justice sanctions might be expected to motivate abusers to go to programs and stay in them. However, evidence suggests that sanctions do not always increase program attendance (Daly & Pelowski, 2000), and they seem to work best for younger, less educated abusers (Saunders & Parker, 1989). Close monitoring seems to have some positive effect on attendance. Such monitoring might involve "attendance checking" by partners, "check-ins" by legal or social service personnel, or immediate court notification of missed sessions. Monthly court reviews also seem to have a positive impact on attendance (Gondolf, 2000).

"Marathon" orientation groups might also improve retention (Tolman & Bhosley, 1991). One marathon group was held over a day and a half. Participants were provided with

an overview of upcoming treatment and taught some concrete skills. The men in this group had a much higher attendance rate than men in the normal orientation groups lasting an hour or two spread over several weeks. Another innovation aims to develop compassionate feelings during the first group session in an attempt to push aside aggression (Stosny, 1994). A video called *Shadows of the Heart* is shown, portraying a very resistant offender at his first agency visit, followed by a scene of the man as a child helplessly watching his father abuse his mother. Abusers identify with both of these scenes and can learn to feel compassion for the child within themselves who never had a chance to heal from childhood traumas. Men in groups with the video and related discussion were more likely to be active in group sessions, take extra homework, and stay in treatment. Other methods for improving attendance use supportive phone calls and handwritten notes from group leaders after missed sessions. These methods seem to work regardless of race, class, and educational level (Taft, Murphy, Elliott, & Keaser, 2001).

Some studies show that men of color are more likely to leave treatment prematurely than white men and thus may benefit from more specialized orientation or treatment groups (Gondolf & Williams, 2001; Saunders & Parker, 1989). Groups composed entirely of men from the same race seem to foster more cohesion than multirace groups. Because unemployment and low educational level may be crucial factors in explaining lower rates of attendance by men of color, programs may need to help them meet basic needs and overcome discrimination. A culturally focused intervention for African Americans was the subject of one study. It was compared with conventional groups composed of all African Americans and with conventional, racially mixed groups. There was a higher completion rate for men with high cultural identification attending the culturally focused groups (Gondolf, 2003, 2005).

EXCERPTS FROM GROUP PROGRAM DIALOGUES AND MATERIAL

In order to take you “inside” groups with various methods, I am including here some group dialogue and handout material. The widely used “Duluth” model tries to help male partner abusers become aware of male entitlement and various forms of coercive and controlling behaviors. In this excerpt (Pence & Paymar, 1993, p. 70), the facilitator and a group member use the Socratic method to raise awareness:

BOB: Well, that’s how I grew up. My dad worked, and my mom stayed home. If a guy can’t support his family, I’ve always thought there was something wrong with him.

MARK: Don’t you think all of us grew up doing what our fathers did? Don’t you think it works both ways? Women grew up thinking that way, too.

FACILITATOR: I just don’t think these things happen out of the blue. Why is it set up like that? That men go out to work, and women work in the home without pay?

PETE: It’s that way in order to keep order.

FACILITATOR: Order?

PETE: Well, some roles have to be set in order to keep things from falling apart.

FACILITATOR: But if men’s work or role is to make money and women’s work or role is without pay, what does that do?

[After several more exchanges, John responds.]

JOHN: We get to make family decisions.

Men are helped to see the links between male socialization and their own behavior. The approach has been criticized because the emotions underlying these behaviors, especially shame, hurt, and fear, are ignored, and therefore men are not helped to move beyond their traditional ways of relating. Confrontational methods may also increase resistance and be less effective than therapeutic methods (Schwartz, Waldo, & Parsons, 2013).

In contrast to the Duluth model, cognitive-behavioral methods use a teaching model that does not involve confrontation. Cognitive restructuring usually has the following elements:

- Recognizing physiological early warning signs of anger, like one's heart racing and an "adrenaline rush."
- Recognizing common cognitive distortions about the event. It may also involve being aware of early traumas, fears, and hurts and male socialization into entitlement norms.
- Cognitive rehearsal involves a behavioral and cognitive reenactment of the event, first thinking out loud and then switching to positive self-talk.

A group handout might help the men see how quickly they generate negative emotions through self-talk or "inner monologues." For example:

"I see her talking with another man; they are probably attracted toward each other."

"I can't let her be tempted, she is my wife, she's done something bad."

"I need to teach her a lesson; I will hurt her as much as she's hurt me."

Examples of positive self-talk might include the following:

"She really does care about me. I trust we have a good relationship."

"Relax, take a deep breath, and focus on caring for myself right now."

"Love means not holding on tight. She can't love me if it's forced."

Cognitive-behavioral methods are often integrated with a focus on reducing male socialization, for example, by restructuring male entitlement beliefs. However, the social learning perspective does not blame individual men for holding these beliefs. The approach also acknowledges feelings of anger, hurt, and fear underlying the cognitions.

Healing childhood traumas is an approach that helps elicit empathic responses in offenders. It operates on the principle that they need to heal childhood traumas, often the result of being abused or seeing a parent abused, before they can empathize with others (Browne et al., 1997). Rather than using psychoeducational methods, this approach relies on the group process to build safe, strong bonds among group members. The need to control others is likely to decrease as childhood wounds are grieved and healed. Self-disclosure by the leaders is emphasized over confrontation. Here is an excerpt (Browne et al., 1997, pp. 269–270) from the first phase of the group, which focuses on lessons and feelings from childhood:

FEMALE LEADER: I want to know not what you wrote in your autobiography, but how did you feel when you were writing it?

GROUP MEMBER: I try to live up to the standard that my father set. I have a mixture of emotions that I could not be as good as he was, but I am a better person. . . .

Writing about my life reminded me of the past choices I made. I made the wrong choices, or the choices I made turned out the wrong way. It hurts to look at your bad choices.

MALE LEADER: How does it feel being a victim of your father?

GROUP MEMBER: It is not a good feeling seeing your father kick you and your brother everyday. What I learned from it was nothing until I came here. . . . He hit me with his fist, kicked, (used a) stick. . . . As a child you do not learn anything, but as you grow up you learn. I always thought, when my father hit me and told me that it hurts him more, why are you doing it then? They feel guilty when they do it so that is why they say that.

In a later phase of the group, members integrate their individual socialization with gender role socialization:

GROUP MEMBER: I saw an ad in the newspaper that I liked a lot about a march about World Without Rape.

FEMALE LEADER: I saw that ad, too. Is there a part that had an impact on you?

GROUP MEMBER: Yeah, the part about the learned behaviors. Also when it said, "Free yourself from the prison of violence that you live in and inflict on other people," and that being a hardass does not mean shit. I see a lot of people thinking they are tough when they really are not.

FEMALE LEADER: Thank you for that reaction. Does anyone else have anything to say about that?

GROUP MEMBER: Yeah. I was taught as I grew up that as a man you are not supposed to be hurt or feel hurt about anything. Then I believed it, and it consumed me as I grew older. One time I sat and I cried because I needed it. It was there that I realized that I have feelings also and that I have a right to express them as anybody else. I cry harder when I realize all the time I wasted believing otherwise. Sometimes I feel alone. It took me time to realize that that macho attitude has not gotten me anywhere besides feeling frustrated and stressed. . . . Now that I can identify certain problems that I had in the past, I feel free. I can say to _____, "I like you," without fearing that he is going to think I am gay. I feel that I have spread my wings.

Therapeutic approaches like this one are rarely used in the United States. As described below, they may be most effective with abusers who have certain personality and behavioral profiles.

Among the strength-based interventions is solution-focused counseling (Lee, Uken, & Sebold, 2009, pp. 72–73). Offenders become deeply involved in setting goals, in addition to the clear goals set by the criminal justice system to end violence. They are invited to set goals with statements such as:

"We want you to create a goal for yourself that will be useful to you in improving your life."

"Make it interpersonal so another person can notice the change you've made and possibly be affected by it."

"It is best to keep it small and doable."

They are encouraged to make even small steps and to think of times they achieved the goal before. For example:

- “What do you think someone who knows you well might advise you to work on?”
- “If you were to work on _____ what would you actually be doing that someone would notice?”
- “What is the first small thing you could do that would help with that?”
- “Have you done that before and has it been helpful?”

Once change is noticed, a set of questions helps explore the way it occurred.

- “How did you decide to do that?”
- “How have you managed to increase _____ since last session?”
- “What are you continuing to do this week to keep up this change?”
- “Did you discover any clues about what would be more helpful?”
- “Are there any adjustments that you would make?”

Note that the change is viewed as the offender’s decision, and he is invited to look for the methods he used to bring about the change.

The variety of approaches just illustrated appears to be very much needed given the diversity in violence severity and type and in personality patterns among male abusers (Aaron & Beaulaurier, 2016). Thus many practitioners and researchers conclude “one size does not fit all.”

CULTURALLY SENSITIVE APPROACHES

Various models of cultural sensitivity exist (Williams & Becker, 1994). For example, color-blind programs claim that “differences don’t make a difference,” culturally focused groups pay attention to historical and contemporary experiences of particular cultural groups, and culturally centered programs place a particular culture at the center of treatment and use culturally significant rituals. An example of a culturally focused method might be acknowledging historical traumas to one’s cultural group and grieving the damage done, such as the forced relocation of Native Americans and the slavery and breakup of African American families. An example of a culturally specific ritual would be the burning of sage in a program for Native American men who batter. As programs become more culturally sensitive, they are offering specialized programs that give men the choice of same-race or mixed-race groups. Special programs are available in some cities for African American men, Southeast Asian men, Native American men, immigrant and nonimmigrant Latinos, and men from other ethnic and racial groups (Aldarondo & Mederos, 2002; Carrillo & Tello, 1998; EMERGE, 2000; Healey et al., 1998).

Programs seem to vary in how well they address the heightened resentment by men of color toward the criminal justice system and toward society as a whole for historical and everyday oppression. The EMERGE program in Boston learned that a nonconfrontational approach seems to work best for clients from some cultures. This program also learned to appreciate the diversity within particular cultural groups (Healey et al., 1998). Beyond specific interventions, the entire organizational structure and climate of programs may need to change. Staff members often need more training and information. Two states require that

staff members receive cultural sensitivity training on race and LGBTQ issues (Cannon et al., 2016). Efforts need to be made to hire a diverse staff, to network with the communities of color, and to seek consultation on culturally sensitive approaches (Williams & Becker, 1994).

ASSESSMENT AND INTAKE PROCEDURES

Not all offenders are suitable for group treatment, or they may require supplementary treatment. Therefore, screening mechanisms are important at intake. Barriers to group treatment might include illiteracy, suicide risk, mental illness, and substance abuse. Some programs conduct comprehensive assessment interviews over several individual sessions at intake, whereas others may place offenders immediately into orientation groups or group treatment. Some programs provide individual counseling for men with severe psychological problems, and others refer them to other agencies for these problems. Although there is not a higher than normal rate of severe mental disorders among men who batter, screening for these disorders is important. It is not clear what percentage of men might need treatment in addition to or in place of group counseling, but some evidence suggests that the percentage is small. By contrast, the overlap between substance abuse and domestic violence is high, and there is increasing evidence that severe alcohol abuse is a risk factor for reassault after treatment (Gondolf, 2002). Some argue that alcohol treatment needs to be a standard feature of offender programs (Bennett & Bland, 2009).

HOW EFFECTIVE ARE PROGRAMS?

Many program evaluations exist, but only a few have designs rigorous enough to produce firm conclusions (see reviews by Aldarondo, 2002; Babcock et al., 2016; Babcock, Green, & Robie, 2004; Davis & Taylor, 1999; Ekhardt et al., 2013; Feder & Wilson, 2005; Gondolf, 2004; Saunders, 2008; Tolman & Edleson, 1995). Some early studies showed promise for changing attitudes about gender roles, reducing anger directed at the partner, and decreasing child abuse. A number of studies compared treatment completers and non-completers. However, completers and noncompleters usually differ on motivational level and demographics, and therefore these studies are not very useful. Several studies used arrest records in quasi-experimental designs, but they only reveal the “tip of the iceberg”; use of victim reports yield much more valid but much more disappointing results. Experimental studies in general show few significant findings. Seven studies comparing different approaches did not find major differences (reviewed in Saunders, 2008). The approaches compared were:

1. Semistructured self-help groups versus a structured educational model versus a combination of the two.
2. A feminist-cognitive-behavioral model versus a process-psychodynamic model (however, there were differences depending on the type of abuser).
3. Cognitive-behavioral group therapy versus supportive group therapy. The supportive group clients showed greater gains on negotiation skills and perceived ability to refrain from verbal aggression.
4. Court-mandated treatment versus a community service control condition.

5. Abuser program plus monthly judicial monitoring versus abuser program plus court monitoring based on level of compliance versus monthly court monitoring only versus court monitoring based on level of compliance versus a condition consisting of abusers with neither monitoring nor treatment. A weakness of this study was a low victim interview rate.
6. Six months of treatment and 1 year of probation compared with men on 1 year of probation only. This study also had a low victim interview rate.
7. Culturally focused counseling in all–African American groups versus conventional counseling in all–African American groups versus conventional counseling in racially mixed groups.

Studies comparing couples groups and men's groups have also been conducted. These studies tend to include only intact couples and women with no injuries or fear of abuse. Two small sample studies showed no differences between the two approaches (Brannen & Rubin, 1996; O'Leary, Heyman, & Neidig, 1999). In a large-scale experiment conducted in the U.S. Navy, four conditions were compared: cognitive-behavioral men's groups, cognitive-behavioral "quasi-couples" groups (although many wives did not attend), rigorous monitoring, and stabilization and safety (Dunford, 2000). The men's groups and quasi-couples groups used similar content, but the couples groups placed more emphasis on communication training. There were no differences across the four conditions.

When researchers attempt to combine the results of many studies in meta-analyses, the results do not reveal much additional information (for a review, see Eckhardt et al., 2013; Saunders, 2008). Cognitive-behavioral and Duluth-style programs do not show different outcomes. Studies using arrest records show positive results, but the more stringent indicator, victim reports, shows very little effect from treatment. Overall, treated groups have about 5% lower recidivism rates than untreated groups. This difference may seem very small, but it is not too surprising, because clients are generally resistant to change and have severe and chronic problems. Many medical treatments, for example for cancer, have equally small effect sizes and are considered successful.

A PROMISING DEVELOPMENT: MATCHING CLIENT TYPES WITH GROUP TREATMENTS

A promising development is matching treatment to the motivational stage of the offender. This matching may be more important for treatment success than any particular theoretical approach. Evidence shows that abusers in the most advanced stage of change are most likely to use strategies to end the violence, and they blame their partners less (Eckhardt, Babcock, & Homack, 2004; Levesque, Gelles, & Velicer, 2000; Scott & Wolfe, 2000). A Web-based treatment using these principles also showed good results (Levesque, Ciavatta, Castle, Prochaska, & Prochaska, 2012). Promising also is a focus on the therapeutic relationship and special motivational techniques, both for increasing attendance and for reducing abuse (for a review, see Babcock et al., 2016). A close therapist–client collaboration and group cohesion have been related to lower levels of psychological and physical abuse (Brown & O'Leary, 2000; Taft, Murphy, King, Musser, & DeDeyn, 2003). Even one or two sessions of special motivational techniques at intake have shown positive results in promoting offenders' engagement in treatment and in offenders being less likely to blame their violence on external factors (Kistenmacher, 2000; Musser, Semiatin, Taft, & Murphy, 2008).

Another promising avenue for further research is the matching of offender types to the type of treatment. In the study comparing feminist-cognitive-behavioral and process-psychodynamic treatments, those with antisocial personalities had lower recidivism rates after a feminist-cognitive-behavioral group, and those with dependent personalities had lower recidivism rates after a process-psychodynamic group (Saunders, 1996). Victim reports long after treatment were used. Typology research consistently shows three types of abusers when organized by personality disorder, severity of violence, and generality of violence (Aaron & Beaulaurier, 2016). Following are case examples (Saunders, 2009, pp. 174–175) of the three types, including notions about the most effective interventions for each type (based primarily on research by Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000, and implications discussed in Saunders, 1993):

David: Family Only, Suppressor Type

A police department receives a call from a woman who says that she is afraid of her estranged husband, David, who is outside her apartment door pleading to see her. She is referred to an agency that can help her file a restraining order. She is reluctant to do this, partly because it could affect his reputation. He is a 44-year-old highly respected physician. She reports that he broke her wrist a few months earlier but she is now thinking of reuniting if he agrees to couples' counseling. Police records show a single arrest for a minor traffic accident while he was under the influence of alcohol.

This type of abuser is the least severely and least frequently violent. He has the least extensive criminal record and is not likely to abuse substances. He has the least hostility toward women, and his communications skills are similar to those of men in unhappy marriages. He appears to be perfectionistic and overinhibited—trying to “stuff” his emotions. He is likely to respond well to criminal justice interventions and to skills-based treatment. Of the three types, he is the one who could be considered a candidate for couples counseling.

Jack: Antisocial and Generally Violent

A police dispatcher receives a call from a hospital emergency room. A woman wants her boyfriend, Jack, arrested for severely bruising her about the face and neck. He previously assaulted her to the point of causing a miscarriage. He is the same man the police arrested a few months ago for a drunken brawl with three men in a bar. Jack is a seasonal construction worker in his mid-30s. He has a long history of alcohol-related crimes, including an assault on a police officer when he was in his early 20s. After serving time for that assault, he served 2 years in prison for drug dealing. As a youth, he lived in foster homes and juvenile treatment centers.

The antisocial, generalized aggressor is violent inside and outside of the home and has the longest arrest record of the three types. He has the highest frequency and severity of violence, including sexual assault. He is likely to have a history of substance abuse and crimes as a teenager. He probably experienced severe physical abuse as a child and as a result developed the motto “the best defense is a good offense.” He is hostile and domineering in most of his communications and justifies violence more than other types. He is not overly attached to his partners and might say “good-bye, good riddance” when they want to leave. Like most antisocial criminals, he is slow to learn, and it may take multiple arrests and divorces for him to learn the impact of his actions. His childhood wounds may be difficult to treat because he tends to cover them with substance use and other means of repression.

He seems to respond well to structured, skills-based programs. He probably needs long-term treatment and close probationary supervision.

Brian: Emotionally Violent/Abandonment Fears

A suicide hotline worker calls the police for aid. She would like the police to check on a 23-year-old man, Brian, who has called them several times threatening suicide. He now says he has a gun and wants to “execute” himself. He is separated from his wife and young son and realizes how much he has hurt her through his abuse. He has slapped her and ridiculed her severely. In the last episode of violence, she was holding their son. He has no criminal justice history. As a child he was affected by his mother’s severe mental illness and abuse from his older brother. Especially painful was the way in which his mother humiliated him in front of his friends.

The emotionally volatile–borderline type fears abandonment and as a result is jealous and dependent. He is responsible for moderate levels of injury to his partner and may have a history of some arrests and perhaps sexual assault. In childhood, he was likely to have experienced rejection, humiliation, or the death or mental illness of a parent. His stance toward his partner is “I hate you—don’t leave me.” He appears to be at highest risk of stalking, separation violence, and suicide and homicide. As a result, criminal justice sanctions may have little impact. Treatment aimed at resolving childhood traumas may be effective, along with methods for reducing physiological arousal.

WHO IS MOST LIKELY TO SUCCEED IN GROUP PROGRAMS?

An important consideration in accepting men into group programs or providing specialized services for them is knowing their likelihood of treatment failure. A fairly small percentage of abusers seem to account for a large percentage of severe and frequent violence after treatment. Factors consistently related to reassault are alcohol abuse and severe personality disorders (Jones & Gondolf, 2001). Not surprisingly, the chronicity and severity of prior assaults or arrests are good predictors of assault after treatment. One prognostic indicator scale showed that substance abuse and severity of domestic abuse predicted recidivism. Another analysis showed the following factors were associated with reassault: younger age, not having children, heavy drinking, emotional abuse or threats, low help-seeking by women, and the women’s use of a shelter (Gondolf, 2002).

COORDINATION WITH OTHER COMMUNITY SYSTEMS

Offender group programs may hold the most promise when they are part of a coordinated, community-wide effort (Babcock et al., 2016). There is growing evidence that combining interventions (arrest plus prosecution and/or treatment) is more effective than any one intervention. For example, greater offender involvement with prosecution, probation, and counseling has been related to success (Murphy, Musser, & Maton, 1998). Information sharing among agencies regarding danger assessment also seems to be useful (Shepard, Falk, & Elliott, 2002). As previously mentioned, court reviews seem to improve treatment compliance (for a review of six of these studies, see Cattaneo & Goodman, 2005).

Gondolf (2002) describes several system changes likely to reduce reassault: (1) having three to four long sessions per week in the first few months, the period in which reassaults are most likely to occur; (2) more continuous support for the men's partners from case-workers and advocates, as only 8% of the partners in his study had contact with battered women's services 3 months after intake; (3) moving the offenders more quickly into abuser programs; (4) pretrial referral and "fast-track" prosecution, similar to drug courts.

INNOVATIONS AND UNANSWERED QUESTIONS

Innovations have been tried but have yet to be evaluated. Some controversies have also arisen that might be resolved through research.

- *Prison programs.* Lengthy, prison-based programs are common for sex offenders but seldom used for domestic violence offenders, most likely because only a small percentage of men who batter are identified in prison populations.
- *Reduction of psychological abuse.* Rates of psychological abuse often remain high after treatment and can have severe impacts on survivors.
- *Integrated substance abuse and offender interventions.* Integration with substance abuse services is difficult, probably because some basic assumptions about the causes of problem behaviors differ so much across the two fields. The greatest promise might come from programs that use the same group leaders for both problem areas.
- *Trauma-based interventions.* Increasing attention is being placed on resolving the childhood traumas of men who batter, but further development and evaluation are needed.
- *Leader gender.* Controversies exist over the use of male–female versus male–male cotherapy or co-leadership of groups, but as yet no outcome studies have been published. Group members do perceive some advantages to mixed-gender facilitation (Roy, Lindsay, & Dallaire, 2013).
- *Treatment length.* Evidence on the impact of treatment length or intensity is inconsistent and thus requires further research (Babcock et al., 2016).
- *Conjoint approaches integrated with gender-specific ones.* More work is needed to determine which couples might benefit from couples approaches. In addition, the screening mechanisms for this approach need further study. Initial results show that careful screening—for example including only women who are motivated for conjoint counseling, feel safe, and have not suffered severe violence—appears to protect women from reabuse (Stith et al., 2011).
- *Program standards and practice guidelines.* Controversy occurs in some states because the standards may be highly specific, tied to government funding, and not evidence based (for reviews, see Babcock et al., 2016; Cannon et al., 2016; Gefner & Rosenbaum, 2001; Maiuro & Eberle, 2008). Further research on many elements of standards, such as treatment length and theoretical orientation, will help to inform this controversy. In other fields, professional groups have developed "practice guidelines" that allow enough flexibility for clinical judgments to be made (e.g., the American Psychological Association and the International Society for Traumatic Stress Studies).

CONCLUSIONS

Groups for the treatment of partner abuse most often use cognitive-behavioral and gender resocialization methods. Despite the existence of many outcome studies, very few are rigorous. A promising avenue for more research is matching the type of offender with the type of treatment. Eventually, the most dangerous offenders might be reliably identified and placed into intensive intervention “tracks.” Fortunately, methods for reducing attrition are yielding promising results. Increased attention to cultural competence is another promising development. However, the integration of abuser treatment, survivor support, and criminal justice interventions may yield the greatest success for ending partner abuse.

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CHAPTER 21

Group Work with Immigrants and Refugees

IZUMI SAKAMOTO
SIDONIA COUTO

Group work with immigrants was at the core of the inception of social work over a hundred years ago (Lee & Montiel, 2009; Sakamoto, 2003; Sullivan, Mesbur, & Lang, 2009). In the settlement house movement, Hull House and other major settlement houses in North America offered group-based programs for neighborhood children and adults that built skills and knowledge and provided opportunities for socialization and recreation, such as theatre groups, sewing groups, cultural information groups, and others. In addition, early social workers worked side by side with immigrants to address social injustices such as child labor, poor labor and sanitary conditions, voting rights for women, and many others (Addams, 1910; Lee, 2009).

In a highly mobile, transnational world where international migration is more common than ever before (Elliott & Segal, 2012; Segal & Heck, 2012), many industrialized countries, including the United States and Canada, have immigration policies driven chiefly by economic interests, in which countries try to attract high-skilled immigrants as human capital to maintain their economic prosperity (Wilson, Sakamoto, & Chin, in press). In addition to voluntary immigrants, there are refugees and migrants without statuses who are forced to move due to intense global politics, war, political oppression, and poverty (Drachman, 2014). Garcia (2009) notes that immigration is increasingly gaining public attention in the United States, much like it was historically when immigration waves surged. She reminds us that “social work practice with immigrant populations poses many complicated challenges due to the multiple issues associated with the immigrant experience, ranging from personal adjustment issues to regional and federal policy initiatives” (Garcia, 2009, p. 79). Indeed, the issues immigrants and refugees potentially face in their countries of resettlement, such as the United States and Canada, are numerous. According to Garcia, some of these issues arise from societal and legal contexts and consist of *increased border security* (which leads to increased detention of undocumented immigrants and more measures to criminalize immigrants); *harsher employer/landlord penalties* (e.g., increased fines for employers hiring

undocumented workers); *increased severity in citizenship/residency pathways* (e.g., more expensive processes with more requirements); *enhanced surveillance initiatives*; and *modified guest worker programs* (pp. 83–84). While written in the context of the United States, these trends mirror those in Canada and other Western nations in the post-9/11 world, where there are growing concerns about “terrorists,” “foreigners,” and racialized others from “other,” non-Western countries (cf. Bhuyan, Jeyapal, Ku, Sakamoto, & Chou, 2017). Needless to say, these societal and legal contexts greatly affect and restrict the lives of immigrants and refugees in these countries of resettlement.

It seems that there are many jobs cut out for social workers to work with immigrants and refugees, given these increasingly restrictive political and legal climates. However, there is a dearth of social work literature on work with immigrants and refugees in North America; for example, many textbooks on clinical social work (e.g., Brandell, 2011; see Gitterman, 2014, for an exception) do not have chapters focused on social work with immigrants or refugees. Moreover, when the literature does focus on immigrants and refugees, it tends to be geared toward social work with individuals and families, not necessarily with groups. For example, a few books solely dedicated to social work with immigrants and refugees (Balgopal, 2000; Chang-Muy & Congress, 2009; Potocky-Tripodi, 2002) do not have sections devoted to groups. In fact, in the subject indexes of these books, group work is absent. Rather, these textbooks tend to be organized by practice areas (e.g., mental health, health—Chang-Muy & Congress, 2009; Potocky-Tripodi, 2002), key issues (e.g., legal issues, employment—Chang-Muy & Congress, 2009), life stages (e.g., older adults, adolescents—Chang-Muy & Congress, 2009), or ethnic/racial groups (e.g., African immigrants—Balgopal, 2000).

Furthermore, there is a serious gap in the literature on group work with immigrants and refugees. In a search within the journal portal of *Social Work with Groups*, only eleven articles from 1978 to 2015 had the words *immigrant(s)*, *immigration*, *migrant*, or *refugee(s)* in their article titles, whereas 199 articles (including editorials and book reviews) had a mention of any of these words anywhere in the article (e.g., historical article referring to Hull House). The first-ever encyclopedia on social work with groups published recently (Gitterman & Salmon, 2009) covered 109 topics; it had, however, no entry about group work with the words *immigrants* or *refugees* in them.

The gap in the literature for group work with immigrants and refugees, however, does not necessarily mean that there is a gap in group work practice itself with these populations. Quite the contrary, at least in the context of Toronto, Canada (where we are located), social workers in public settings such as hospitals, community health centers, schools, long-term care institutions, and other community-based social service agencies regularly provide programs to service users/clients¹ who are immigrants or refugees. Within these organizational settings, a significant portion of social work practice is made up of group work, and often immigrants and refugees are members in these groups, reflecting the general demographics.

One of us (I. S.) is an academic who has used groups to conduct community-based participatory research with immigrants and other marginalized communities for the past 20 years and, more recently, has led university–community collaborations on immigrant employment issues toward social change. The other (S. C.) is a mid-career social worker who was previously employed in a social service agency exclusively focused on working with victims of torture and war, most of whom entered Canada as refugees. She has planned and led group work with adolescents and adults who have experienced torture, and her first-hand clinical and community experience are reflected in case studies and other parts of this chapter. As we are mindful that this book is published in the United States for international

audiences, this chapter focuses mainly on practice issues, rather than providing fuller discussions on international differences in immigration policies and political climates that inform available social services and social activism.

LITERATURE AND PRACTICE

Although it is limited and small in size, literature on group work with immigrants and refugees does exist. Broadly speaking, it includes theoretical approaches and practice models (e.g., structural approach, Breton, 2000; using an interpreter as cofacilitator, Dubus 2015; single-session groups for Vietnamese refugees in Hong Kong, Chan, 1991), reports on case studies or practice-related issues (e.g., a group for Chinese immigrant parents whose children are transitioning to an American preschool, Tan, 2011; multifamily groups for Latino immigrants addressing trauma and support post-9/11, Ludwig, Imberti, Rodriguez, & Torrens, 2006), evaluation research (exploratory evaluation for immigrant Latina women's group, Marrs Fuchsel, 2014), and research-based groups (e.g., participatory oral history project, Traver, 2005).

The kinds of issues addressed in such literature on group work with immigrants and refugees include utility of group work to address common concerns experienced by immigrants and/or refugees (e.g., the role of social group work in refugee resettlement, Glassman & Skolnik, 1984; group work as a protective factor for immigrant youth, López, 1991; themes of reflection and abandonment in group work with Caribbean adolescents, Glasgow & Gouse-Sheese, 1995); challenges and strategies to overcome the problems of designing groups for immigrants and/or refugees (e.g., Chan, 1991); resolving conflicts in groups; and other practice and teaching-related issues (e.g., Gonzalez, Lord, Rex-Kiss, & Francois, 2011). The age groups served varied from adolescents (e.g., Glasgow & Gouse-Sheese, 1995; López, 1991) to older adults (e.g., Dubus, 2015). There are also groups for parents (e.g., Gonzalez et al., 2011; Tan, 2011) and caregivers (e.g., Chan & O'Connor, 2008; Lee & Yim, 2013). Many of the groups were ethnicity-specific (e.g., Chan & O'Connor, 2008; Lee & Yim, 2013; Ludwig et al., 2006; Marrs Fuchsel, 2014; Marrs Fuchsel & Hysjulien, 2013), whereas others included immigrants and refugees across different cultures/languages/countries (Traver, 2005).

It is important to also note various kinds of group work that occur out of unions and other grassroots community organizing work. For example, Susan Chandler and Jill Jones (Chandler, 2013; Chandler & Jones, 2011) have documented how migrant women have organized themselves to fight for and secure fair wages and humane working conditions over the years in Nevada's Culinary Union (Local 226 of UNITE HERE), a "grassroots organizing union under the leadership of women activists" (Chandler, 2013, p. 235). Professional social workers may not necessarily be involved in these initiatives, but grassroots leaders from within affected communities may organize themselves for collective actions. It is very likely that these types of groups involving immigrants and refugees may not often be documented in popular media or academic literature, and thus they go unnoticed by social workers. It is important for social workers to be cognizant of this so that we do not erroneously assume that the dearth of academic literature in this area indicates a lack of community leadership and group work effort by, and for, immigrant and refugee communities.

Overall, a small body of literature on group work with immigrants and refugees exists but does not formulate a sizable knowledge base, and it is difficult to generalize what constitutes dominant theories, models, or evidence to work with this diverse population. To

that end, instead of offering a comprehensive review of the literature, we present types of group work practice with immigrants and refugees that do exist and focus on a case study to extract lessons on working with immigrants and refugees.

TYPES OF GROUP WORK IN PRACTICE

From what we have observed in the literature and in actual practice in the context of Toronto, Canada, there are several approaches/models that seem to be common in group work practice with immigrants and refugees. These include: (1) education and psychoeducational groups (Lee & Yim, 2013; Letendre, 2009; Tan, 2011); (2) support and mutual aid groups (e.g., Chan & O'Connor, 2008; Gonzalez et al., 2011; Steinberg, 2009); (3) trauma-informed groups (e.g., Ludwig et al., 2006; Stewart et al., 2011); (4) antioppression, empowerment, and/or advocacy group work (Chupp, 2009; Fleming, 2009; Gutiérrez & Lewis, 1999; Hudson, 2009; Sakamoto, 2009); and (5) groups for research purposes (e.g., Gutiérrez, Sakamoto & Morson, 2003; Sakamoto, 2014; Traver, 2005).

Education and Psychoeducational Groups

In the context of Toronto, Canada, education and psychoeducational groups are perhaps the most common type of groups facilitated by professional staff such as social workers. This likely has to do with the availability of government funding for immigrant-specific programs, such as settlement programs and job search programs for newcomers, which are widely offered in immigrant-serving community organizations.

Typical job search workshops are sponsored by the Canadian federal government (Citizenship and Immigration Canada, 2015) and are focused on topics such as job search strategies, resume and cover-letter writing, mock interview sessions, and others. The facilitators may be social workers, social service workers, or adult educators or may have other professional credentials. The extent to which these workshops may incorporate mutual aid may depend on the facilitators and organizational culture/mandate.

Another example is healthy eating and diabetes prevention groups offered in community health centers, geared to address the fact that immigrants' health often deteriorates after they have been in Canada for several years (MacDonald & Kennedy, 2004; Sakamoto, 2007; Sakamoto, Ku, & Wei, 2009).

Support and Mutual Aid Groups

Support and mutual aid groups are also commonly offered to immigrants and refugees (e.g., Glasgow & Gouse-Sheese, 1995). These groups may be organized around activities and/or by common experiences or identities. For example, there are drop-in groups on cooking, knitting, and arts and crafts for newcomer women. In addition to gaining skills in these activities, these groups offer space for participants to connect with one another, given that isolation is one of the major issues newcomers face. A local community health centre in Toronto (*Women's Health in Women's Hands Community Health Centre*) collaborates with several organizations advocating for people of African descent living with HIV/AIDS and offers weekly groups for women from Caribbean, African, and black communities (mostly immigrants or refugees) living with HIV/AIDS. In this group, women exchange information and offer support to each other in some structured and unstructured program time.

Groups can also serve the purpose of both support and psychoeducation (e.g., Sakamoto et al., 2016; Tan, 2011). In describing Korean American dementia family caregivers' experience, Lee and Yim (2013) highlight the importance of both education and social support from other caregivers as part of the effectiveness of the group work with this population.

Trauma-Informed Work

For trauma survivors of rape and childhood abuse, group work in general can illuminate the sense of universality, or being "all in the same boat"; facilitate mutual aid; reduce isolation; improve self-esteem and self-efficacy; and correct "distorted views of social relationships" (Knight, 2009, p. 241; also see Yalom, 2005). A group of Canadian interdisciplinary scholars (Simich, Beiser, & Mawani, 2003; Stewart et al., 2008, 2011) have explored the impact of support groups and social support for refugees, many of whom have experienced torture, war, and persecution. The impacts of group work, in addition to those listed by Knight (2009) above, include reconnecting refugees to one another in a meaningful and healthy way, as the experience of torture, conflict, and persecution can degrade the trust and social bonds in communities and society; enhancing informational, instrumental, and emotional social support, which is crucial to settlement and integration into the host country; and providing refugees with insight about how to cope with problems, how to seek help in a host society, how to seek formal supports from organizations and government, and increased confidence in being able to cope with problems (Simich et al., 2003; Stewart et al., 2008, 2011). These points are illustrated in the case study later in this chapter.

Anti-oppression, Empowerment, and/or Advocacy Group Work

Immigrants and refugees can also engage in group work to empower themselves, challenge the structural barriers they experience in the host country, and advocate for improved social and economic conditions for their communities (e.g., Chandler, 2013). In the early 1990s, a group of Somali women in Toronto, who were mostly refugee claimants, came together, with the help of the Canadian Centre for Victims of Torture (a not-for-profit charitable organization), to create a support group (Mohamed, 1999). The women used the contacts they made within the group to share practical settlement information and establish a supportive social network. However, they also used this opportunity to organize themselves and work towards changing the institutions that were affecting their lives (Mohamed, 1999). For example, at this time, refugee claimants were prohibited from accessing subsidized housing in Toronto, despite the fact that many had low incomes and could not afford market rent housing (Mohamed, 1999). To address this issue, the Somali women began to advocate for their community by writing petitions and sending letters to local politicians about this cause (Mohamed, 1999). Eventually, their advocacy efforts were successful, with the law changing to allow for refugee claimants to have access to subsidized housing. The collective resistance that the women demonstrated has had long-lasting impacts for all refugee claimants that followed them, as it has enhanced their equitable access to housing.

Groups for Research Purposes

Groups can be used for the purpose of research and can be designed to have the merits of social work groups (e.g., Gutiérrez et al., 2003; Traver, 2005). For example, community-based

participatory research is often conducted using groups, and these groups could offer the benefits of education, psychoeducation, support, mutual aid, empowerment, trauma work, anti-oppression, and/or advocacy. I (I. S.) led a research project in which the data collection happened through a series of arts-informed focus groups with skilled immigrants to highlight employment challenges that immigrants face (Bleuer, Chin, & Sakamoto, 2017; Chin, Sakamoto & Bleuer, 2014; Sakamoto, 2014). In collaboration with a drama specialist, activities drawn from psychodrama and drama therapy were utilized to access the kinds of cultural knowledge that is understood but is difficult to articulate in words (tacit knowledge; Sakamoto, Chin, & Young, 2010). Some of the outcomes of this research project included a play (theatre), which was performed for groups of immigrants, service providers, policymakers, and employers to challenge how the general public thinks about the employability of immigrants and to affect change. This research project later informed the establishment of a provincial human rights policy on immigrant employment (Ontario Human Rights Commission, 2013).

Groups That Draw from Multiple Models and Orientations

It is important to note that many groups may involve more than one aspect of these theoretical and practice models/orientations. The following case study encompasses the components of multiple models/orientations, such as education, support, and mutual aid, and trauma-informed work, all at once. This case study is based on real-life examples of many refugee women in groups. The specific group descriptions and details of the group members' identities and circumstances have been changed to protect the anonymity and confidentiality of the actual individuals. With the limitation in page length, we are not able to cover all aspects of this group; however, we focus on some key aspects of planning and implementing group work with immigrants and refugees. These include assessment, membership, format (open vs. closed), accessibility, and using a trauma-informed approach, which also recognizes the impact of resettlement factors in clients' lives. Some of these themes may be applicable to refugees but may not be relevant to many immigrants (e.g., trauma resulting from the experience of war, conflict, and political persecution); at the same time, we believe that any other issues raised would shed light on important aspects of group work for immigrants alike.

EXTENDED CASE STUDY: A REFUGEE WOMEN'S SETTLEMENT, MENTAL HEALTH, AND WELLNESS GROUP

Assessment

Sara and Monica are social workers, working together at a settlement agency in Toronto, which provides support to refugees and immigrants who have experienced torture, war, or organized violence in their countries of origin. Sara is a white Canadian-born woman from a blue-collar Anglo-Saxon background who has been providing support to refugee groups in Toronto for 7 years. Monica is a Latin American woman who came to Canada 10 years ago as a refugee from Colombia. Monica worked as a psychiatrist in Colombia but attained a social work degree after arriving in Canada. She has also been providing support to refugee groups in Toronto for 5 years. The workers recognized the tremendous resilience of this population group; however, they were growing increasingly concerned about the many female refugee clients they saw for individual counseling who were experiencing trauma-related symptoms and complex barriers to settlement in Canada. Wanting to address the mental health concerns of these clients

and assist their navigation in Canadian systems, Sara and Monica set out to conduct a needs assessment concerning the applicability of coordinating a group program for refugee women to provide mental health and settlement-related psychoeducation, support, and resources. They were able to translate questionnaires into a variety of languages (Somali, Tamil, Amharic, Tigrinya, French, and Spanish) and distributed them to the female refugee clients who came to the agency for services. They also conducted verbal interviews with clients who were not literate in their own languages nor in English. Additionally, they conducted a focus group in English to assess the mental health and settlement needs of the population. Although Sara and Monica wanted to directly inquire about clients' individual and community mental health needs, they also understood that they would have to conduct the needs assessment sensitively. They were conscious of the type of language they used in questionnaires and the way they communicated questions during their focus groups so as to not deter potential participants to the group. Instead of focusing directly on mental health, questions focused around the women's sources of resettlement stress, their health and well-being, their experiences of managing stress in Canada, the coping strategies employed by clients, and their experience of accessing and receiving social and health resources to cope with distress. The workers welcomed the women to the focus group in an informal way, providing refreshments and background music to ensure that participants felt comfortable. The workers also began the session by providing a thorough orientation to the agency and providing a space for clients to ask questions about the organization and its programs and services. Some of the assessment feedback provided by participants indicated that many did indeed experience distress but that they tended to manage their stress by seeking support from family members and that they were reticent to share personal problems with other community members. Some clients, who did not have familial supports in Canada, shared that they relied on other institutions for assistance (such as mosques, churches, and settlement providers), with varying degrees of success. Many of these clients expressed a desire to interact with other newcomer women to combat social isolation and to attain advice and guidance about resettlement. The women also expressed a lack of information about other formal or community supports and services that could help them manage stress.

An assessment prior to the start of the group (e.g., needs assessment) is vital in ensuring that there is a need and desire for the group and that the program's objectives and activities meet the interests of the client population. Because refugees generally experience a multitude of complex needs after arriving in the country of resettlement, it is easy for workers to be paternalistic and assume they know what types of support refugees need. However, assessment is a crucial part of the development of a support group; missing this step or completing it incorrectly can result in a group that is not functional or that does not address the actual needs of clients. Commonly, needs assessments can be conducted via focus group, questionnaires, and interviews. Using a mixture of modalities is recommended to capture client's needs, as there may be a wide variety in the English-language skills and native language literacy reflected in refugee groups. Verbal methods are often preferred over written methods to ensure that the format of the needs assessment is accessible to all participants, regardless of English or native language literacy. Written materials should also be translated into a client's native language when possible. The content of the needs assessment must be tailored to the population group, which requires some knowledge or experience about the group and how their beliefs about the subject matter may affect the needs assessment process and outcomes. Given their experience in the settlement sector, both Sara and Monica understood that there can be stigma around the topic of mental health among newcomer

populations, that mental health is understood differently across cultures, and that some participants would not openly identify themselves or their family members as individuals experiencing mental health problems (Drachman, 1992; Fang, 2010). Words such as *stress* and *health* were therefore used, as they were identified as less stigmatizing terms that could still elicit information about mental health concerns and needs. The workers also understood that the state of clients' health and well-being did not exist in a vacuum but that they were intricately connected to their resettlement experience of having to navigate harsh and sometimes punitive service delivery and sociopolitical structures (Breton, 2000). Accordingly, the workers explored the women's experiences of trying to access resources that could enhance their settlement.

As found in the needs assessments that Sara and Monica conducted, many newcomers described that they engaged in problem solving by first seeking the assistance of family, friends, and elders and then might turn to faith groups, religious leaders in the community, and other community support mechanisms if they were not able to resolve concerns within their immediate familial circles (Danso, 2002; Drachman, 1992; Stewart et al., 2008). Some newcomers also attain support from families and their ethnocultural communities because of their previous experiences of racism and discrimination while accessing formal supports (Stewart et al., 2008). This has also been found among women of color in the United States, who are more likely to seek assistance from informal mutual aid and support networks instead of more formalized mental health services (Manning, 1998). Workers may then want to consider how groups can incorporate existing community level supports with more formalized supports (Gutiérrez & Lewis, 1999). Social workers can attempt to build on the strengths of clients' networks and the assets and resources already present in their collective communities by incorporating discussions, activities, and the presence of family, elders, religious leaders, and other community supports into the group programming.

As seen in the case, although some refugees may describe concern about discussing personal issues in public, many also convey a need to seek support from others in similar life circumstances. Research has demonstrated that support groups can enhance refugees' feelings of belonging, life satisfaction, perceived social support, and integration; reduce social isolation and loneliness; and give them access to networks that provide necessary settlement information (Simich et al., 2003; Stewart et al., 2008, 2011). In one study with Cambodian refugee women, it was found that, although there were reservations among the women about sharing problems with others and fears that personal disclosures could mar their family's reputations, the women also reported that talking, sharing, and supporting one another helped them decrease their sense of isolation and promoted their problem-solving skills (Dewitt & Adelson, 2007).

Membership: Inclusion and Exclusion Criteria

Monica and Sara decided that the support group would be open to refugee women of all countries of origin, ethnic groups, languages, cultures, and religions. Although they recognized the benefits of ethnocultural-specific and linguistic-specific groups, they also wanted to engage in mental health promotion with as many newcomer communities as possible. The group was diverse, with members from Somalia, Ethiopia, Eritrea, Kenya, Sri Lanka, Pakistan, and Colombia. One of the clients who registered in the support group was Mariam.

Mariam was an Ethiopian refugee woman who had been living in Canada for approximately 1 year. Like many other Ethiopian refugees, she fled political persecution

in Ethiopia, where her husband, parents, and brother were imprisoned due to their political ideologies. With her two children, she lived in a refugee camp in Kenya for many years. Without the protection of a husband, she was gang-raped in the refugee camp, which resulted in her contracting HIV. Although Mariam lived with many settlement and mental health challenges, she did not reach out to the Ethiopian community in Canada for assistance. Mariam did attend the support group once, but never returned. Several of the group members had attained Mariam's phone number and tried calling Mariam personally, urging her to continue attending the group, but Mariam revealed to the workers that despite the diversity of the group, she was not comfortable being around other Ethiopian people. She had been raped by Ethiopian men and lived with a mistrust of her own community as a result. She also experienced the shame and stigma associated with being a raped woman in her culture. Furthermore, she was extremely afraid that others in the community would find out about her HIV-positive status, which could negatively affect her social standing. Despite the social workers' efforts to ensure Mariam's privacy and the confidentiality of her lived experiences, Mariam chose to not attend. Respecting her self-determination and recognizing that Mariam was not yet ready to engage in group programming, Sara and Monica made arrangements for Mariam to find other supports with which she felt more comfortable and less triggered by her surroundings. As a result, Mariam enrolled in the agency's English classes and group skills training programming, in which she improved her English-language skills and learned an employment-related skill. She also made several new friends and felt less isolated in these classes. These experiences increased Mariam's self-esteem, and she began to see the benefits of interacting with others in group settings. She later informed Monica that she would be willing to try attending the support group in the future.

The inclusion and exclusion criteria for a group may depend on the objectives and activities of the program. The advantages of providing a support group solely to newcomers who speak the same language or to newcomers from the same country of origin is that participants may share a language, values, norms, and cultural understandings. This can decrease the need for interpreters or cultural brokers, especially when the service provider shares the language and culture of the support group participants. However, social workers cannot make the assumption that clients from the same country of origin are homogeneous and share language, culture, or experience, given the ethnic, linguistic, and religious diversity that exists in many countries.

Ethnospecific- and linguistic-specific criteria can also increase group cohesion among participants, who may find it easier to relate and find support from other members of their communities. Many refugees feel that only these members can accurately understand their premigration, migration, and postmigration lived realities. Indeed, refugees' mental health, self-esteem, and general health outcomes are improved by the experience of validation and support from others from the same ethnic background or country of origin who have also endured the common challenges of migration and resettlement (Simich et al., 2003). For refugees who have lost their intimate relationships in the communities they left behind, having access to the affirmation and support of people from their countries of origin can help them re-create the personal relationships they had with family and friends, which can enhance their confidence and capacity to manage life in the host society (Kawachi & Berkman, 2001; Simich et al., 2003).

Providing a safe space in which clients of the same country can come together to share and support one another can also be a mechanism of healing for survivors of torture and war. The experience of war, political oppression, violence, and torture can destroy the social

bonds in a society, and survivors may have to learn how to rebuild trust with others from their communities (King, 2011; King & Sakamoto, 2015). The support group can therefore act as a method for reuniting communities whose relationships have been degraded by conflict (Stewart et al., 2011). At the same time, newcomer clients who have survived violent conflicts between different ethnic, religious, or cultural groups in their countries of origin may express discomfort in participating in a group with members of their own communities whom they do not trust. In a study of Colombian refugees in Quebec, Arsenault (2010) found that many of the participants avoided interacting with other Colombians or discussing political issues because they did not want to be exposed to the reproduction of former tensions that existed in their countries of origin. Some clients may also be fearful that members of their community have ties to the oppressive forces in their countries of origin that led them to flee and seek asylum in the host country. Given these complexities, it is recommended that social workers not assume that refugee groups who are from the same country of origin will have a natural predisposition towards one another and recognize that some refugees may experience distress if they have to interact with members of their own community (Arsenault, 2010). Social workers should also be cognizant of the sociopolitical context that clients are coming from and the various tensions that exist between groups. In support groups, social workers must be careful if they mention the political situations that clients come from and ensure that clients do not feel pressured to engage in group discussions in which they have to disclose their political opinions (Arsenault, 2010). As a result of these challenges, in some cases, it may be more appropriate to have culturally mixed groups, in which refugees are able to interact with people from many different countries of origin (Arsenault, 2010).

A Note on the Gendered Experiences of Refugee Women

Social workers may decide to set inclusion/exclusion criteria based on gender and age to build group cohesion and to ensure that the group addresses the vulnerabilities and strengths that are unique to specific newcomer groups. Mariam's experiences as a refugee woman are not uncommon, as many refugee women have experienced gender-based violence in their countries of origin or during migration, including rape, sexual assault, sexual slavery, forced prostitution, forced marriage, forced pregnancy, forced sterilization, domestic violence, and pregnancy and childbirth as a result of rape (Mossallanejad, 2015). As a result of the violence already experienced in their country of origin, refugee women are at increased risk of experiencing gender-based violence in their country of resettlement (Bartolomei, Eckert, & Pittaway, 2014). Indeed, female refugee clients must cope and manage interpersonal and systemic sexism, misogyny, and living within patriarchal structures, even after being resettled. Many also experience intense shame and stigma associated with surviving rape, having children born of rape, or being single or widowed in their country of resettlement (Bartolomei et al., 2014). Moreover, due to prescriptive gender roles and traditional responsibilities, women are more likely to be the caregivers of others (including children and parents), and these responsibilities can place a strain on newcomer women's lives and their mental health (Bartolomei et al., 2014). Addressing these unique challenges can be possible within a same-gender group, as it can provide an opportunity to tackle complex issues and have in-depth discussions about mental health, sexual health, reproductive health, and stigma in a safe environment. This may not be possible in a mixed-gender group due to the prevalence of shame and the impact that prescriptive gender roles have on participant's behavior in mixed-group settings.

Format: Open versus Closed

Monica and Sara started the refugee women's support group with the intention of it being a closed group, with psychoeducational and mutual aid model approaches. They recognized that issues of shame and stigma and concerns about confidentiality were prevalent for the group members. They believed that having a closed group would enhance clients' sense of privacy. At the first meeting, the social workers discussed the group contract, including group norms, describing the general rules that clients would follow. Part of the group contract was to attend the group regularly on a weekly basis for 8 weeks. Upon hearing this, several of the clients said that they could not agree to this because they had several other commitments in the community, and they could not confirm whether they would attend the group on a weekly basis. Understanding that some of the clients may not attend regularly and that they had been presumptuous in assuming that the group should be closed, the service providers collaborated with the clients in deciding that the group would be an open group. Indeed, throughout the 8 weeks, the workers saw that although some of the women attended each session, most of the women came periodically to the group (i.e., attending 4–7 sessions). However, the workers also noted that making it an open group meant that there were new attendees every week. The reason was that the participants were spreading the word about the group in the community, attracting more women to attend. By making it an open group, the workers made the group format realistic for the registered women and more accessible to other refugee women in the community, who only learned about the group via word of mouth, once it had started.

Although closed groups can enhance clients' sense of confidentiality and privacy, open groups may work best with refugee populations for practical reasons. Refugees' lives can be complex when they are new to the host country, as they must contend with ongoing challenges related to resettlement. Newcomers may have to attend to housing, legal/immigration, medical, educational, or employment concerns. This can make it difficult for some clients to attend a group at a set time on a weekly basis in a predictable manner. As a result of struggling with posttrauma-related issues, such as trouble sleeping, nightmares, low mood, anxiety, and flashbacks, participants may also not be able to attend all sessions. For example, clients may have difficulty attending morning sessions due to problems with insomnia or may periodically struggle with low mood, which decreases their motivation to attend the program.

Open groups can require increased flexibility on the part of facilitators, who must work to build trust and group cohesion throughout each session. Because each session has a slightly different makeup of participants, facilitators may have to engage clients on an ongoing basis by employing icebreaker or trust-building activities, which help participants find commonalities in the group. Facilitators may also have to regularly recap group norms at the start of each session and highlight topics and discussions from previous sessions to bridge knowledge and skills gaps between new and previous attendees.

Psychoeducational models can be an effective approach for group work with refugees, as they have proven to be successful in enhancing knowledge, skills acquisition, and behavioral change in issues such as stress reduction, managing mental health, managing life transitions, and adopting healthy behaviors (Roffman, 2004). Psychoeducational groups can also provide participants with information about the options that are available to them in coping with distress or issues of concern, and this enhances participants' ability to make informed decisions about their lives (Roffman, 2004). This can be empowering for refugee communities, who generally experience a lack of access to information and decision-making

resources that can enhance their health and well-being because of systemic barriers including a lack of awareness of services, a lack of culturally sensitive services, a lack of trust in health professionals/systems, and a lack of targeted mental health promotion geared to this population. Furthermore, as psychoeducational models are focused on acquiring specific knowledge and skills, and as there is a significant amount of direction provided by facilitators, there is less pressure for participants to disclose sensitive information about their problems (Roffman, 2004). In view of the fact that many newcomers' cultures dictate that they should not openly discuss negative or difficult feelings and experiences, a psychoeducational approach, which does not require the sharing of personal information, may be more culturally appropriate for some refugees (Roffman, 2004). A focus on specific issues and goals also helps to build group cohesion among heterogeneous participants (Roffman, 2004).

Accessibility: Language Issues and Location

Interpreters can be used to increase the accessibility of a group, particularly when the group is linguistically homogeneous, the facilitator does not speak the clients' language, and only one type of language interpreter is needed for the entire group. The use of interpreters can become cumbersome in heterogeneous groups where participants speak many different languages. In these cases, interpreters can be used if only a small number of participants require interpretation. Nevertheless, this can make it challenging for facilitators to build group cohesion, as group activities may take longer to process when facilitators and participants must stop to make time for interpretation.

Other complications can also arise with the use of interpreters. Some clients refuse to use interpreters, as they may have concerns that their personal information will not be kept confidential by interpreters and that gossip may spread about them within their communities (Kirmayer et al., 2011). Refugee clients may not see interpreters as neutral figures, especially if the interpreters are from their countries of origin. They may be fearful about the interpreters' personal political ideology or membership in a conflicting ethnic group and how this will affect confidentiality and the quality of the interpretation (Arsenault, 2010). Refugee clients also experience fears that information they share could be shared with the government of the country that they fled from (Payne, 2015). Payne (2015) describes that many Iranian refugees in Canada fear that there are Iranian government agents in Canada. Given this fear, it is less likely that these clients would share information about themselves in front of an interpreter.

Communication between workers and participants, or between participants, can also be negatively affected by interpretation if the interpreter does not accurately convey the empathy or compassion that is intended by the speaker (Farooq & Fear, 2003). Interpreters may also deemphasize client's contributions to the conversation, especially when they are not in line with mainstream principles. It has been found that interpreters can diminish clients' indigenous knowledge and understanding of concepts such as mental health and treatment practices when they do not conform to Western ideologies (Pain, Kanagaratnam, & Payne, 2014). To mitigate these challenges, facilitators can ensure that they are using reputable and trained interpreters with experience providing interpretation services to refugee groups. Practically, this can be difficult due to a lack of government funding for interpretation or a lack of available interpreters who speak specific languages. It can also be beneficial for facilitators to use the same interpreter throughout the entire group to build trust, to continually introduce participants to the interpreter (especially in open groups, where there are new

participants each session), and to remind participants about the confidentiality agreement that interpreters are bound to at the start of each meeting.

The location of the group should be based on what is most accessible to potential participants. This may be a settlement agency at which clients feel comfortable accessing services or another nonthreatening community location that clients are already familiar with, such as a public library or community recreation center. However, depending on the purpose of the group, participants may prefer a location that is private, such as a community organization that only registered clients can access. As such, the client will not encounter others in the community who will find out that they are receiving particular services. For example, a torture survivor may not want to self-identify as a survivor in his or her community because of the stigma associated with trauma, mental health, or the label *refugee*. In this case, meeting in a public location that many people can come to (e.g., a library) may not be preferred. Similarly, a newcomer attending an LGBTQ group might not be comfortable meeting in such a public place where he or she could be easily identified and labeled by community members as attending a group specifically for LGBTQ-identified people.

Resettlement and Trauma-Informed Group Work

During the first session of the group, workers spoke to the women about what types of topics they would like to discuss throughout the group. The members suggested various topics, ranging from understanding Canada's educational system to finding ways to help community members struggling with mental health concerns. One participant, Leila, shared that she felt she could generally cope with the multiple day-to-day stressors she encountered in Canada because they did not compare to the monumental distress she experienced knowing that her children remained in insecure conditions in her country of origin. Leila had fled Afghanistan due to gender-related violence and persecution. When she left, she was able to take her two daughters with her but had to leave her two sons behind. Although she had some contact with them, she lived in chronic fear that they would become targets for harassment, threats, and violent recruitment attempts by the Taliban, as they were nearing their teenage years. Leila said, "I appreciate everything that Canada has done for me: giving me asylum and safety. I don't take that lightly. But I still can't sleep at night. I can't concentrate in English class, it's hard for me to remember my appointments, and I still feel depressed. I know that I will never feel okay, never be able to move on with my life, until all my children are here with me in Canada." Recognizing that the need for family reunification was a major and consistently reported source of distress, Monica and Sara asked a refugee/immigration lawyer from a local legal aid clinic to provide a workshop to their group during the second session about family reunification and the various legal options available to participants looking to reunite with family members abroad. The participants made many inquiries during the session and asked for the lawyer's contact information for follow-up. Afterward, Monica and Sara spoke to participants about techniques on coping with feelings of loss and facilitated a discussion about strategies for how clients can remain feeling connected to separated family members. At the end of the session, participants thanked facilitators and the workshop presenter for organizing the workshop. As a result of the success of the second session, Monica and Sara noticed that there were five more participants who attended the subsequent meeting, as members had spread the word about the relevance of the group content in their community.

Group practice with refugee populations has the most impact when the activities and discussions recognize the resettlement factors that are affecting client's lives, choices, and

opportunities. Because refugees encounter multiple barriers to resettlement in host countries, workers should provide the space for clients to dictate what types of information they would like to explore within the group that will enhance their ability to navigate the sociopolitical landscape they live in. The systemic barriers refugees endure can include a lack of information on how to navigate Canadian society and systems, poverty, social isolation, lack of affordable housing, a lack of secure immigration status, language barriers, lack of employment and educational opportunities, interpersonal and systemic racism, and other forms of discrimination, such as ageism, homophobia, transphobia, sexism, and xenophobia. As noted in the case, many refugees also struggle with family separation and can contend with extremely long immigration processes, bureaucratic red tape, and expensive procedures such as DNA testing in order to reunite with their family members (Danso, 2002). The lack of family reunification can have detrimental effects on the psychological and economic well-being of newcomers, whereas having access to the social networks of family and extended relatives can help newcomers solve problems and manage the social and economic problems they encounter in a host society (Hein, 1993).

Despite the many known complex needs and barriers to integration and the evidence that refugees require instrumental supports (such as information about housing, immigration, and navigating Canadian systems) to feel safe and secure in the host country, some refugees have shared that they did not receive adequate or culturally appropriate resettlement information and orientation about Canadian life and society after arriving in the country (Danso, 2002; Stewart et al., 2011). Alternatively, workers conducting groups with refugees have the opportunity to flexibly incorporate relevant settlement-related resources, knowledge, and discussions into the group activities. This is crucial, as it is not possible to appropriately address the physical and mental well-being of this population without recognizing the impact of resettlement factors and the social determinants of health.

In one session of the support group, Monica and Sara invited a workshop facilitator from an organization that specializes in providing support to women who have experienced gender-related violence. The facilitator provided the women with information describing what gender-related violence is and what women can do if they, or someone they know, are being abused. Although the workshop was presented in a psychoeducational manner and the facilitator did not ask for personal disclosures, some of the participants shared personal information of their own experiences of violence. One woman, Khadija, who had been living in Canada for approximately 3 years, said that she had had to flee Pakistan because she had been persecuted for being a women's rights activist. Khadija then told the group that her experiences of violence were worsened when she arrived in Canada without proper identity documentation and that she was detained by Canadian border officials for 1 month until she and her refugee lawyer could attain adequate documents proving her identity. Khadija described the despondency and sense of injustice she experienced as a result of her detention in Canada: "I had fled my country of origin because of injustice. Then the first thing that Canada did to me was detain me. I have a hard time trusting people in this country now." Lola, a refugee woman from Colombia, became agitated during the workshop, and, after Khadija's disclosure, she stormed out of the room. Noticing that Lola was in distress, Monica went to find her. During this time, Sara and the workshop facilitator continued the discussion with the rest of the group. Speaking in their native Spanish, Monica convinced Lola to go into her office to discuss why Lola was so irritated. Lola angrily said that she had no desire to hear about other women's problems with violence and persecution because she had experienced enough violence in her own life. Lola told Monica that she was not "crazy" and found no use in reliving the past. At this point,

Lola started crying and revealed to Monica that she too had been detained in Canada upon arrival and had only been released 6 months ago. Lola said that she did not want to be reminded of this difficult time. Monica acknowledged Lola's feelings, experiences, and discomfort with the subject material. However, Monica also made sure that Lola understood that other participants had the right to share their stories and a right to be heard, in the same way that Lola had a right to leave the room, as she needed to. Recognizing that Lola may have been triggered by the information shared in the room, the worker took the opportunity to privately speak to Lola about triggers, what they are, and what she could do to manage them in the future. Lola eventually went home, leaving the group early. Afterward, Monica and Sara debriefed with one another about the session and recognized that they had not adequately prepared the group for the workshop. They had not expected a member to disclose personal traumatic information and had not yet had discussions with the group about how to manage triggers or what to do if they felt uncomfortable in the group and needed to take a break. Lola did return to the group the following week, and Monica and Sara made it a point to discuss group norms that highlighted respect, confidentiality, and listening skills. The workers also provided psychoeducation to clients about what triggers are (stimuli that set off one of the senses, such as touch, smell, taste, sight, or sound, and remind an individual about a past traumatic event), how to identify one's own triggers, and grounding techniques that can be used to manage triggers.

Trauma-informed practices are evidence-based approaches that acknowledge the prevalence and impact of trauma on individuals, families, and communities, that recognize that trauma is not simply an individual pathology but that it occurs within the context of oppressive historical and structural systems, and that prioritize holistic models of intervention (Blanch, 2008; Zahraei, 2015). Accordingly, workers conducting group practice should understand the premigration and migration life experiences of refugees and the impact these may have on their well-being and the group functioning. Refugees may have endured premigration traumas such as detention, torture, war, rape, the murder of family and friends, the need to leave family and friends behind in dangerous situations, forced labor, and starvation (Drachman, 1992). Many refugees have lost their homes, worldly possessions, and connections to their community (Drachman, 1992). During their migration, refugees may have lived in refugee camps for many years waiting for resettlement, lived in hiding in neighboring transit countries, or traveled for prolonged periods of time in unsafe conditions, placing them at risk for violence such as organ trafficking. After arriving in the host country, some refugees experience detention due to a lack of identity documents or security concerns, and this can be further traumatizing for refugees fleeing violence, particularly minors (Keller et al, 2003; Kronick, Rousseau, & Cleveland, 2011; Robjant, Hassan, & Katona, 2009).

As a result of experiencing trauma, refugees may display symptoms such as memory problems, a lack of concentration, insomnia, low mood, anxiety, nightmares, flashbacks, withdrawal, hypersensitivity, hypervigilance, use of substances, mistrust, paranoia, low self-esteem, lack of motivation, survivor guilt, self-blame, and alienation. Some clients may not identify as having mental health concerns but may instead present distress in culturally appropriate ways by complaining of somatic concerns such as physical pain (Fang, 2010). Although these symptoms are normal responses to the abnormal events of trauma, many refugees may be diagnosed with posttraumatic stress disorder (PTSD) in the host country, despite the concerns that a diagnosis of PTSD does not accurately reflect the complicated individual and social repercussions of persecution, war, torture, and the trauma of resettlement (isolation, racism, hostility) that refugees endure (Pain et al., 2014). Indeed, physicians experienced in providing refugee care have noted that the diagnosis can have limited clinical

utility, as the Western interventions for PTSD (such as trauma-focused cognitive-behavioral therapy or exposure-based treatments) may not be appropriate for refugee populations (Pain et al., 2014). The trauma of torture and war is a type of psychosocial trauma that originates from oppressive sociopolitical frameworks, structural violence, and social/economic disparities between social classes (Madariaga, 2002). Given that the roots of trauma are structural and that trauma affects whole societies by degrading the trust and social bonds in communities, biomedical, psychiatric, or psychological Western interventions that are focused on diagnosing individual pathology and on “processing trauma” through traditional talk therapies are inadequate in addressing the impact of torture, persecution, and war (Madariaga, 2002; Pain et al., 2014). Instead, community-level interventions, which change the social relations in society and promote collective healing, may be more appropriate (Madariaga, 2002). By their very nature, support groups offer an opportunity for members to socialize, find support in one another, and re-create meaningful bonds and their ability to trust others in the community, thus mending fragmented social relations.

Workers should tread carefully if attempting to discuss trauma in refugee groups. Workers should be mindful that refugees participating in a group may be at different stages of settlement, and this can determine what types of activities and discussions are suitable for the group. Addressing trauma may be inappropriate for refugees who do not yet feel safe or secure in Canada due to current stressors such as insecure immigration status or precarious housing. Their lives may not yet be stable enough to withstand the distress associated with discussing or processing trauma. Because refugees’ trauma histories can be particularly horrific, it is easy for workers to become paternalistic and focus on clients’ trauma as the source of their distress (Payne, 2015). However, refugees may not describe past trauma as their main concern, as they may be more interested in coping with immediate issues related to attaining language skills, affordable housing, or employment (Payne, 2015). Workers should therefore ensure that they encourage the empowerment of clients to define their own problems and not make assumptions about what type of intervention they require to overcome past trauma. Furthermore, refugees may describe that they have no interest in discussing the trauma they endured and instead engage in a process of “active forgetting” (Payne, 2015). In a study with Southeast Asian refugees living in British Columbia, Beiser and Hyman (1997) found that those who avoided thinking about the past were less likely to develop depression. The researchers hypothesized that suppressing past traumatic events may be an adaptive way in which refugees cope with extreme adversity and that this suppression can be functional and therapeutic (Beiser & Hyman, 1997). It may, therefore, be more appropriate for workers to focus group discussions on clients’ dreams, ambitions, hopes, and aspirations, to orient themselves to the future (Pain et al., 2014).

If addressing trauma or other taboo subjects, workers must be cognizant that personal disclosures in groups can be extremely uncomfortable and inappropriate for members from cultures in which the well-being of the family and community are prioritized over individual concerns (Drachman, 1992). Accordingly, some of the refugees’ cultures may dictate that they should practice “emotional restraint” and not share personal challenges in public, in order to preserve social harmony within the community and to prevent families from being shamed or dishonored (Drachman, 1992). Particular refugee groups may experience specific challenges related to disclosure. Refugee women who have experienced sexual violence may not likely disclose this type of trauma in a group context and may be particularly fearful of gossip about them spreading throughout the community, as they may come from cultures and countries in which virginity and chastity are highly valued and in which women who have experienced rape are stigmatized, shunned, or no longer considered to be marriageable

(Arsenault, 2010; Drachman, 1992). Discussions of this nature may therefore not be appropriate for group work with this population, and the issues of shame and stigma may be better addressed in individual counseling. Many LGBTQ newcomers may not feel comfortable disclosing their sexual orientations and gender identities because doing so might make them stand out from the group and expose them to negative attitudes from their community members (O'Neill, 2010); at the same time, for those whose sexual orientations or gender identities were the reasons for persecution in their home countries, it may be very important for them to let others know of their identities. Workers should recognize the discomfort associated with personal disclosures and not misconstrue it as noncompliance in group participation (Gutiérrez & Lewis, 1999). Instead, workers can conduct discussions related to trauma or other taboo subjects in an informational manner without placing pressure on members to discuss personal challenges. This can sometimes open up the space for members to feel comfortable disclosing personal information and attaining support from others; however, workers should also not expect that this will occur. Workers must also be prepared in handling disclosures sensitively, so that discussions do not result in retraumatization, conflict, client attrition, or broken therapeutic alliances between service provider and client. As seen in Toronto, social workers can also aid the creation of peer-led groups for LGBTQ newcomers for mutual support.

SUMMARY AND CONCLUSION

In this chapter, we have presented a brief overview of group work with immigrants and refugees, followed by a case study of a refugee women's group focusing on resettlement, mental health, and wellness. Table 21.1 summarizes the key issues to consider in planning for and implementing group work with immigrants and refugees—some discussed in this chapter as well as several other issues that could not be included in this chapter due to page limitations. While these “challenges” and “strategies” were developed with group work with refugees in mind, many of them do apply to group work with various immigrants.

We would also like to emphasize that immigrants and refugees are heterogeneous, even when they come from the same country or the same ethnic/religious/cultural/language backgrounds, and that assessment should always precede any planning of group work. In order to be aware of multiplicities of issues that many immigrants and refugees face, while at the same time being careful not to generalize our knowledge to any immigrants or refugees that we meet, it is important for social workers to learn more about current affairs and history in different parts of the world, not only from the mainstream media and books but also through independent media and other alternate sources of information. In working with people whose backgrounds and experiences may be vastly different from our own, it is paramount for social workers to continuously develop critical consciousness about our own identities, standpoints, and positionality and how they affect what we know and perceive, as well as the kinds of power we may exercise (Pitner & Sakamoto, 2005, 2016; Sakamoto & Pitner, 2005).

NOTE

1. In this chapter, we use “service users” and “clients” interchangeably to denote members (or potential members) of group work groups.

TABLE 21.1. Group Work with Immigrants and Refugees: Challenges and Strategies to Work with Them

Challenges	Strategies
	<u>Planning phase</u>
Lack of access due to economic barriers (e.g., lack of transportation funds, child care and refreshments/food)	Secure funding to provide child care, transportation allowances, and refreshments for group members. Underresourced agencies may seek to collaborate with other agencies to provide these services. For example, agencies can partner with local food banks to secure refreshments for groups.
Restricted help-seeking behaviors from clients, decreasing group registration	Collaborating with newcomers to conduct outreach to immigrant and refugee communities. Newcomers can provide valuable information about best methods in accessing immigrant and refugee communities, and workers can encourage service users to advertise the program via “word-of-mouth” referrals. This demonstrates a respect for service user’s expertise, enhances the credibility of the worker, and builds trust between workers and service users.
Funding that restricts permitted group activities or eligible participants based on immigration status.	Using funding from various sources, to provide a mixture of activities relevant to group needs, to service users of all immigration statuses. Using volunteer resources to provide alternative activities (yoga, meditation, etc.) Collaborating with other agencies with diverse funding to provide activities.
Language and interpretation	If the worker does not speak the language of participants, the agency can collaborate with another organization that has the relevant language capacity. Secure funding for interpretation. Use a committed/trained interpreter. Be mindful that service users may not always feel comfortable with an interpreter due to concerns about confidentiality. Continually introduce participants to the interpreter and remind participants about the confidentiality agreement that interpreters are bound by. Translate outreach material to as many relevant languages as possible to enhance access. Be mindful of using nonstigmatizing language/terminology in outreach materials.
Literacy issues	When literacy is an issue among group members, consider using methods not dependent on written language for informed consent, assessment, and evaluation to enhance access for nonliterate members. Instead, workers can use methods such as verbal consent, the use of numbers or colors given verbal questions, focus groups, and observation for evaluation and assessment.
Retention of group members, or regular attendance of group members (due to client appointments, mental health concerns, etc.)	Having an open group, where registered clients can drop in as per their availability, and where new clients can register on a continuous basis.

(continued)

TABLE 21.1. *(continued)*

Challenges	Strategies
	Implementing group work
Confidentiality/privacy and/or stigma over status as a newcomer or trauma survivor	Having a group in a secure confidential location where clients do not have to “out” themselves in the community as a refugee or trauma survivor. Not asking participants to disclose personal information about their trauma histories in a group. Instead, participants can be asked to share information about non-taboo subjects, and this can help build bonds and trust within the group. Highlighting the group norm of confidentiality regularly throughout the sessions. Group norms can be posted in the room, provided in handouts and repeated orally. This is particularly important for an open group, where new members may be attending each session.
Addressing trauma	Avoid being paternalistic and assuming that client’s trauma is source of their distress. Address issues that clients identify as sources of distress, including social determinants of health, such as attaining language skills, affordable housing, or employment. Understand that some clients have no interest in discussing the trauma they endured, and instead engage in a process of “active forgetting,” which may be an adaptive way that refugees cope with adversity. Focus on client’s dreams, ambitions, hopes, and aspirations, to orient themselves to the future. Understand that support groups encourage members to socialize, find support in one another, and thus re-create meaningful bonds and their ability to trust others in the community, which, in turn, would mend fragmented social relations. These are interventions which promote collective healing from trauma. Conduct discussions related to trauma, or other taboo subjects, in an informational manner, without placing undue pressure on members to discuss personal challenges.
Lack of security in Canada (e.g., participants who are refugee claimants, undocumented immigrants, other temporary residents who are waiting for permanent residency)	Be mindful that “processing trauma” may not be a preferred method, especially for service users who do not yet have safety/security in the host country and whose lives may not yet be stable enough to withstand the distress associated with discussing trauma. Instead, workers may want to be resettlement focused and flexibly incorporate settlement-related resources and knowledge (related to immigration, safe housing, etc.) into the group activities.
Preexisting power dynamics and tensions from premigration conditions (e.g., in groups where group members are from the same country of origin or region, the group can re-create tensions that existed between ethnic, political, or religious groups)	When possible, workers should educate themselves about the world history, geography, and existing/recent conflicts in different parts of the world and what roles their own country might have played in them, if any. Be cognizant of the sociopolitical contexts that service users are coming from; be mindful when mentioning the political situations that service users come from; and ensure that service users do not feel pressured to engage in group discussions in which they have to disclose their political opinions.

(continued)

TABLE 21.1. (continued)

Challenges	Strategies
Power disparity between worker and group members	Conduct an appropriate initial assessment, and continuous assessments throughout the program to ensure that group activities are addressing needs identified by service users. Ensure that group norms are decided upon collectively with facilitators and members working together, to create realistic “rules” that all can abide by. Create space for members to share their indigenous knowledge and practices and to promote their own well-being, as well as that of others in the group. This also means that workers would be accommodating and open to new ideas and ways of doing things that may not be familiar with to them. Be mindful that group members may be from cultures that dictate that they should demonstrate respect and gratefulness for workers, and this may mean that they avoid disclosing their opinions or feelings if these could offend the worker. Workers must then be conscious of making decisions on a consensus basis and not assume that clients are consenting to ideas presented by the worker. Ensure that workers encourage the self-empowerment of group members to define their own problems and not make assumptions about what types of intervention they require to overcome past trauma and/or current resettlement issues.

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CHAPTER 22

Intergroup Dialogue

Engaging Difference for Social Connectedness and Social Change

BIREN (RATNESH) A. NAGDA

Social group work, with its historical commitment to democracy, uses various approaches to address issues of diversity and justice (Alissi, 2001; Coyle, 1935; Henry, 2003; McNicoll, 2003). “Groups have been seen as vehicles to educate for democracy through democratic procedures within the group and the agency, as vehicles for social action within and beyond the agency, as opportunities for members to learn to accept and respect differences, and as microcosms of society” (Shapiro, 2003, p. 13). Even though social work with groups is considered to include those groups that social workers participate in and “individuals join to enhance their functioning, enrich their lives, ameliorate problems experienced by organizations and communities, produce social change, and promote social justice” (Garvin, Gutiérrez & Galinsky, 2004, p. 1), tensions remain as to whether group work should have a social goals and social change or a remedial and individual change orientation (Breton, 2012; Cohen & Mullender, 2006; Henry, 2003). Some social work educators also lament the shift in social group work toward more intragroup, interpersonal, and intrapsychic concerns (Bargal, 2004; Breton, 2005; Carr, 2004). “Advocates of social justice-oriented group work assert that as social work claimed professional status and the notion of professional helping, group work as a politicized strategy for social change waned whereas therapeutic group work gained ascendancy with its attendant practice of professional power and control” (Dudziak & Profitt, 2012, p. 240).

One possibility for reconciling the tensions between social group work for individual change or for social change is to conceptualize group work as an interconnector across different levels of practice, one that allows for simultaneous attention to the micro-level complexity of individuals and groups embedded in relationships within a larger macro-level social context (Cohen & Mullender, 2006; Shapiro, 2003). In fact, Coyle (1935) emphasized that group work is only as efficacious as its ability to offer personally meaningful

experiences that were *also* socially significant. Similarly, Alissi (2001) underscored “the simultaneous commitment to both the welfare of the individual and the betterment of society through the pursuit of social change and social action” (p. 4) as distinguishing group work in social work from other helping professions. Thus social group work can be “the site for individual, collective, and social transformation, blurring the boundaries between the traditional, fragmenting conceptualization of micro, mezzo, and macro levels of social work practice. Social justice-oriented group work integrates all three” (Jacobson & Rugeley, 2007, p. 26). Such an approach can deal with the full range of social justice—from how social injustices affect individual group members to how group dynamics are a microcosm of larger societal dynamics to how group members can be mobilized or empowered to engage in social justice-oriented actions and social change (Alissi, 2001; Gitterman, 2003, Jacobson & Rugeley, 2007). Importantly, social change here represents change in “social functioning, social relationships, the social environment, social institutions, and change in social systems” (Henry, 2003, p. 67) and is differentiated from societal change. Social group work for social justice, therefore, represents an actual participatory experience of social engagement and change in the actual group setting and empowers for social and societal change outside the group setting.

Within social group work for social justice, further questions remain, however, about who is involved in the groups or how practitioners conceive of the group members. Whether groups provide what Henry (2003) refers to as prototype experiences of democracies or engage members in developing skills and attributes for democratic participation, these groups appear to implicitly conceptualize members as a homogeneous entity, be they members of marginalized groups or community residents gathering to discuss and effect change on local issues. Race, gender, class, and other identity differences within groups that may influence and are influenced by differential societal experiences, broadly referred to as intergroup issues, are not explicitly addressed (Bargal, 2004). Breton (2005) especially cautions about the homogenization of groups and the heavy reliance on, and narrow conception of, mutual aid as the core practice principle for group work:

reducing mutual aid to an intra-group phenomenon has led us to concentrate on the healing power of mutual aid and to forget its liberating power. Liberating power is linked to extra-group and to inter-group solidarity, which leads to strength, action and change at the social, economic and political levels. Intra-group solidarity, which is how we have come to see mutual aid, leads mainly to strength, action and change at the personal level. Concern with personal strength, action and change is part of the very fabric of our profession, but it is simply insufficient if our work is to have any relevance whatsoever to the poor, the racially, ethnically or sexually oppressed, to exploited children, youth and old people, and to all the others who are relegated to the margins of society, and await opportunities for empowerment. (p. 115)

Checkoway and Aldana's (2014) reconceptualization of democracy to diverse democracies is helpful in rethinking the role of difference in social group work. Recognizing the increasing demographic diversity and continued social stratification, they call specifically for education to include “information about social identities, group similarities and differences, patterns of dominance and subservience, and struggles to challenge structures that perpetuate injustices” (p. 1895). In essence, social group work should not only focus on those in the same boat but “awaken [our] consciousness to others in ‘other boats’” (Breton,

2005, p. 116). To capture the potential of diverse democracies and what is required to get there, political theorist Allen (2016) offers a vision of a “connected society.” Drawing on precepts of social capital theory, Allen centers on the necessity of bridging relationships—relationships across differences that befriend strangers and that usually require stepping out of the taken-for-granted social networks—for democratic progress. In contrast, bonding relationships are intragroup oriented, constructed around similarities and usually occurring within boundaries of comfort. In a parallel vein, Clements (2012), a peace and conflict scholar, connects democracy to sustainable peace and development. He posits that “sustainable peace is most likely in stable, cooperative, and compassionate communities that place a higher value on trust, equality, and welfare than safety and security” (p. 344). Especially important, he asserts, is attending to bottom-up relational ethics and community building in contrast to top-down macro-level impositions in the service of sustainable peace. Drawing on the work of French moral philosopher Emmanuel Levinas, Clements distinguishes individualist-minded peace- and community-building approaches that rely on the virtuous qualities of individuals from relational ethics approaches “in which ethical imperatives toward peacefulness and justice flow primarily from relationships . . . more important than individual ‘character’ or ‘virtue’ are relational capacities to care, trust, empathize, reciprocate, and be compassionate” (p. 345).

Clements’s relational capacities, as opposed to individual goodness, compose what Allen refers to as social competence. In an interview with Ramesh (2013), Allen connects social competence to our diverse demographic reality and poses an important question: “Diversity plus social competence at bridging relationships leads to far more effective problem-solving. Therapists help us get better at our bonding relationships. Who helps us get better at bridging relationships?” Social work group practitioners and educators may well challenge Allen’s view that only therapists can better bonding relationships. The practice of social work with groups—founded on the principles of mutual aid, “all in the same boat” and “strength in numbers” phenomena—is precisely about strengthening these very bonds for individual well-being (Breton, 2012; Steinberg, 2010). But, I believe, social group workers can especially lay claim to fostering bridging relationships, which build ties *across* differences *with* strangers and those from whom we are estranged.

It is a vision of a connected, diverse, and just society that guides the work of critical-dialogic intergroup dialogue practice, the topic of this chapter. I expand Allen’s purposing of bridging relationships for effective problem solving to include the goals of social change and social justice, writ large. Moreover, I also conceive these relationships as among groups that are not merely estranged (and presumed equal) but estranged precisely because of inequalities. Thus intergroup dialogue attends to representational diversity within groups and leverages that very diversity to raise consciousness about inequalities, to build relationships across differences, and to mobilize for collective social action and social change. In the rest of this chapter, I first define intergroup dialogue and share the breadth of programs in educational and community settings. I then discuss the multidisciplinary roots of critical-dialogic intergroup dialogue. Next, I turn to an overview of the critical-dialogic theory of change, provide a detailed description of the four-stage practice model, and summarize results of an experimental, mixed-methods field study with randomized assignment. I end by looking at future directions for practice, research, and theory and provide a concluding section that speaks to how a focus on bridging relationships can enable an intergroup approach to social group work for social justice.

DEFINING INTERGROUP DIALOGUE

Broadly speaking, intergroup dialogue (IGD) is a group-based approach to engage issues of diversity and/or justice through relationship building. It brings together members of diverse social and cultural groups in co-learning situations that are guided by facilitators and usually sustained with regular meetings over a period of time. These groups are sometimes affected by historical conflicts or dealing with ongoing conflict or potential of conflict (Bargal, 2004; Gurin, Nagda & Zúñiga, 2013; McCoy & Scully, 2002; Saunders, 1999; Schoem & Hurtado, 2001; Zúñiga, Nagda, & Sevig, 2002). Approaches to intergroup dialogue vary in their relative emphases on relationship building, engaging difference and inequality, and mobilizing for social action and social change. In general, intergroup dialogues vary in being identity-based or issue-based and in conceptualizing difference vis-à-vis a diversity or a social justice analysis (Nagda & Gurin, 2007; Zúñiga & Nagda, 2001).

IGDs occur in a multitude of settings—educational, occupational, and community—and across the age range—young people in middle and high schools, emerging adults in college, and adults in general (Schoem & Hurtado, 2001). Intergroup dialogues in college settings are primarily identity-based with a focus on learning about social identities and inequalities and their impact on intergroup relationships. Examples of subjects of such intergroup dialogues include: race and ethnicity (Ford & Malaney, 2012; Ford & Orlandella, 2015; Gurin, Nagda, & Zúñiga, 2013; Nagda et al., 1999; Nagda & Zúñiga, 2003); gender (Gurin, Nagda, & Zúñiga, 2013; Zúñiga & Nagda, 1993; Zúñiga et al., 2002); sexuality and sexual orientation (Dessel, Woodford & Warren, 2011; Zúñiga & Nagda, 1993); social class (Sanders & Mahalingam, 2012); faith and religion (Dessel & Ali, 2014; Khuri, 2004); and political ideology (Hess, Rynczak, Minarik, & Landrum-Brown, 2010). In contrast, IGDs in community settings are often issue-based; that is, they focus on diversity, difference, and/or disparities in communities manifested in issues such as neighborhood development, immigration, police brutality, academic achievement, affirmative action, and so on (Davidson & Moses, 2012; McCoy & Scully, 2002; Walsh, 2006; also see *www.everyday-democracy.org*). In the international arena, intergroup dialogue informs peace-building interventions in interethnic conflicts (Saunders, 1999).

Intergroup dialogues with middle and high school students are a mix of identity- and issue-based dialogues, but the issues are defined vis-à-vis personal, social, or community development. For example, intergroup dialogues and dialogic practices have been used to engage high school students in learning about and taking action on issues of racial segregation within schools (Johnston-Goodstar & Nagda, 2010) and cities (Checkoway, 2009; Lopez & Nastasi, 2012) or to address violence-related issues, such as bullying (Griffin, Brown, & Warren, 2012) and hate crimes (Derr & Nagda, 2016). Intergroup dialogue practices are integral to developing leadership skills to address specific intergroup conflicts in schools (Spencer, Brown, Griffin & Abdullah, 2008) and in communities (Wayne, 2008). Other efforts are connected to general diversity interventions in schools (Tauriac, Kim, Sariñana, Tawa, & Kahn, 2013), to an annual nationwide initiative on crossing social boundaries (Nagda, McCoy, & Barrett, 2006), or to longer-term national peace-building and development projects (Van Wyk, Nagda, & Robertson, 2005). In Israel, there is a long tradition of Arab–Jewish and Palestinian–Israeli dialogue among youth, with approaches varying from simple diversity, coexistence models to confrontation and narrative models that raise issues of political conflict and power inequities (Bargal, 2004, 2008; Hammack, 2006; Maoz, 2011).

A Critical–Dialogic Approach to Intergroup Dialogue

The critical–dialogic model of intergroup dialogue detailed in this chapter is an integrative approach that involves interacting *across* social identities and inequalities to improve intergroup relationships, learning *about* social injustices on the individual and societal levels, and mobilizing *for* individual and collective change efforts (Gurin, Nagda, & Zúñiga, 2013). Based on a core group work principle of building supportive and connective relationships (Breton, 2012; Garvin, Gutiérrez & Galinsky, 2004; Toseland, Jones, & Gellis, 2004), participants in intergroup dialogues learn from and with each other (Nagda, 2006; Nagda, Kim, & Truelove, 2004). Most distinctive about critical–dialogic intergroup dialogue is its simultaneous focus on building *dialogic* relationships across different identity groups and developing *critical* understanding about these very differences in interests, identities, and inequalities so as to mobilize individual and collective agency for social change and social justice (Nagda, 2006; Nagda & Gurin, 2007). Engaging in dialogue is participating in a process of change because participants are developing new ways of thinking and relating. Critical–dialogic intergroup dialogue, however, seeks to extend these new cognitive and affective dispositions to new ways of acting that empower individuals and collectives to work for personal and social change beyond the dialogue encounter (Breton, 2005, 2012).

Intergroup dialogue scholars and practitioners trace the origins of intergroup dialogue to some common roots: intergroup contact (Nagda, 2006; Nagda & Gurin, 2013; Zúñiga, Lopez, & Ford, 2014; Zúñiga, Nagda, Chesler & Cytron-Walker, 2007), multicultural, social justice, and transformative education (Aldana, Rowley, Checkoway & Richards-Schuster, 2012; Dessel, 2011; Gurin, Nagda, & Zúñiga, 2013; Nagda et al., 1999; Zúñiga et al., 2014), and dialogic communication (Dessel, 2011; Nagda et al., 1999; Nagda & Gurin, 2013; Zúñiga et al., 2014). I discuss these roots next and connect them to current issues in the respective fields.

Intergroup Relations and Intergroup Contact

Intergroup dialogue is part of a longer tradition in intergroup relations that uses group-based approaches to improve intergroup relations (Stephan & Stephan, 2001; Stephan & Vogt, 2004). Emerging out of the intergroup contact movement following World War II and the northward migration of African Americans to join the workforce in the industrial north, the target of these early interventions was prejudice reduction. A guiding assumption of these efforts was that reducing individual-level prejudice, especially among whites as the majority group (or dominant group), would lead to more tolerance and acceptance and thus better relationships between whites and people of color. In articulating the “contact hypothesis,” Allport (1954) challenged the prevailing notion that random contact between different people would automatically lead to cohesive relations and specified the situational conditions that he surmised as necessary to foster positive relationships:

Prejudice (unless deeply rooted in the character structure of the individual) may be reduced by equal status contact between majority and minority groups in the pursuit of common goals. The effect is greatly enhanced if this contact is sanctioned by institutional supports (i.e., by law, custom, or local atmosphere), and provided it is of a sort that leads to the perception of common interests and common humanity between members of the two groups. (p. 281)

Allport's contact hypothesis has informed a multitude of antibias and intergroup education interventions and laboratory and field-based research. A comprehensive meta-analysis of 515 studies, from the early 1940s through 2000, showed that contact across groups does reduce prejudice and that the strength of effects is related to the quality and intimacy of contact (Pettigrew & Tropp, 2011). For example, cross-group friendships that involved disclosing information and spending time together were more effective in reducing prejudice than simply having an outgroup friend and/or a generalized sentiment of feeling close to an outgroup friend. Most of the studies, however, focused on outcomes for the majority group. Less than 15% of the studies investigated the impact of contact on prejudice reduction for minority group members, and the studies that did showed weaker effects for minority groups than for majority groups.

The findings from the meta-analysis, the noted gaps in knowledge, and an increasing concern for real-world significance of intergroup relations interventions have raised important questions in rethinking intergroup contact in the 21st century. First, is reducing prejudice the primary desired outcome of intergroup contact? Scholars have argued recently that intergroup contact still holds promise but for more than simply preventing or reducing prejudice; its goals, and thus methods, should be to improve intergroup relationships (Tropp & Mallett, 2011) and collective action (Dixon, Levine, Reicher & Durrheim, 2012). Second, with an interest to return more to real-world significance and field-based studies, how do we recognize the larger context of direct and structural violence in which intergroup contact interventions are taking place (Paluck, 2012)? This means that that sterile conditions simulated in the laboratory may be neither realistic nor generalizable to everyday dynamics and contexts and that the issues of identities, discrimination, and structural inequalities need to be engaged in the contact. Third, given the lack of focus on minoritized group members' experiences in intergroup contact situations and realistic considerations of identity and power in contact, how do societal asymmetries affect the experience and impact of intergroup contact interventions on dominant and subordinated groups? A growing literature looks at the differing motivations, expectations, and effects of intergroup contact for high-power and low-power groups (Demoulin, Leyens, & Dovidio, 2009; Dovidio, Saguy, West, & Gaertner, 2012; Nagda, Yeakley, Gurin, & Sorensen, 2012). Research shows, for example, that high-power groups prefer to focus on commonalities, whereas low-power groups also want to talk about differences in intergroup encounters (Saguy, Dovidio, & Pratto, 2008), that whites enter interracial contact situations motivated to be liked whereas blacks enter the same situation with a desire to be respected (Bergsieker, Shelton, & Richeson, 2010), and that whites prefer prejudice reduction interventions whereas people of color tend toward empowerment and collective action (Wright & Lubensky, 2009).

Conscientization, Dialogic Education, and Social Justice Education

Dialogue is the encounter between [people], mediated by the world in order to name the world. Hence, dialogue cannot occur between those who want to name the world and those who do not wish this naming—between those who deny others the right to speak their work and those whose right to speak has been denied them. . . . Only dialogue, which requires critical thinking, is also capable of generating critical thinking. Without dialogue there is no communication, and without communication there is no education. (Freire, 2003, pp. 88–93)

Freire's seminal work on conscientization in *Pedagogy of the Oppressed* (2003) underscored the interrelatedness of critical thinking, education, and dialogue, such that one may not exist without the other and together they can have a transformative, liberatory impact. While concerned with issues of poverty and illiteracy, Freire also conceptualized the transformative role education can play in challenging these very injustices. He critiqued the prevailing education system as one akin to banking, whereby teachers enact their dominance by depositing knowledge and information in students who are considered to be unformed empty vessels. Students withdraw this knowledge through rote memorization as needed for examinations. In contrast to banking education, Freire proposed dialogic education in which the teacher–learner relationships and learner–learner relationships are as co-constructors of knowledge. While banking education privileges the expert knowledge of teachers, dialogic education validates the lived experiences of learners and teachers. Such experiential knowledge, varying across those engaged in the encounter, is not taken-as-is, but as a foundation for continued critical thinking, dialogue, and theorizing. Critical thinking refers to analysis that sees interconnectedness of the larger world and people and the ever-evolving and transforming reality, not a static reality. Freire underscored that critiquing social reality and societal structures comes with a conjoint responsibility for reconstructing newer realities and humanizing encounters.

Freire's keen insights on social inequities and mobilizing for social justice have had a lasting impact on progressive education, particularly social justice education. The goal of social justice, according to educator Bell (2016, p. 3), "is full and equal participation of people from all social identity groups in a society that is mutually shaped to meet their needs. . . . Our vision of social justice is a world in which the distribution of resources is equitable and ecologically sustainable, and all members are physically and psychologically safe and secure, recognized and treated with respect. . . . Social justice involves social actors who have a sense of their own agency as well as a sense of social responsibility toward and with others, their society, the environment, and the broader world in which we live." Like many social group workers, Bell sees social justice as a process that "should also be democratic and participatory, respectful of human diversity and group differences, and inclusive and affirming of human agency and capacity for working collaboratively with others to create change" (p. 3). In essence, the milieu of social justice education is conceived of as a microcosm of society with its influence of power dynamics and fractured relationships, while embodying what Freire terms a creative and hopeful possibility for a more egalitarian society. That is, the experience of social justice education should model for learners the larger goal of social justice (also see Horton, 1998).

Social justice education itself is seen as challenging other forms of diversity education (Sleeter & Grant, 2008). The goal of intergroup or intercultural harmony in diversity education meant an appreciation of difference but not to explicitly engage with issues of power, privilege, and oppression (Adams & Zúñiga, 2016; Hardiman, Jackson, & Griffin, 2007). While social justice education explicitly engages issues of identities and inequalities for consciousness raising, there remains a tension about how and how much to engage relationships. Many educators lean toward consciousness raising for individual students without attending to the group dynamics. In many approaches, even when difference and power are addressed, it becomes "a discourse about the marginalized 'other' with little examination of the 'self' at the center of the dominant culture" (Asher, 2003, p. 235). Alternately, the focus can become entirely about the "self" disconnected from the "other," which in classes focusing on race and racism may reproduce a centering of whiteness and white privilege (Applebaum, 2010).

Critical feminist and postcolonial scholars are now challenging the divisive binaries of self and other, oppressor and oppressed, and knowledge and action by emphasizing critical relational engagement of differences (Asher, 2003; Collins, 2013; hooks, 1994; Keating, 2012). To bridge these binaries and strengthen bonds across differences, Collins (2013) calls for understanding how inequities in power and privilege constrain intergroup relationships, for building empathy across differences, and for fostering collective change through coalitions for social change. In the same vein, Asher (2003) offers the development of hybrid consciousness, a recognition of ourselves as both oppressed and oppressor, and understanding the “other” in relation to and not separate from “self.” Anzaldúa (2002) reflects on the paradigm shift occurring in social justice education toward a more critical relational engagement: “[In the early 1990s] we struggled with the recognition of difference within the context of commonality. Today, we grapple with the recognition of commonality within the context of difference” (p. 2). In essence, critical relational engagement calls for eschewing the myopic conceptualizations of commonality as community and difference as division and for embracing engagement of both difference *and* commonality in a personal–political context as potentially and powerfully connective.

Dialogic Communication

Focusing centrally on the critical relational dimension of social justice education and the quality of interactions in intergroup contact marked by asymmetries brings us to the actual communicative interactions across differences. Just as dialogic education gives primacy to the lived experiences of learners and teachers to counter reproduction of authoritarian relationships and subjugation of marginalized knowledge, dialogic communication aims to have those diverse experiences truly engaged and understood to counter oppressive power relations (Freire, 2003) and to build greater self–other bonds (Buber, 1970) and stronger communities (Bohm, 1980). Freire (2003), in proposing dialogic education as a humanizing, liberatory form of education, is clear that dialogue is not an individualistic and interpersonal endeavor but an engaged encounter in and with the larger world. Dialogue, while relational, is also critical. Freire specified some foundational precepts for such critical dialogue. Dialogue comes from a profound care and love for the world to fulfill its potential for all people, both oppressed and oppressors. It comes from humility and connection with others and not out of arrogance, assumptions of superiority, or separation from others. “At the point of encounter there are neither utter ignoramuses nor perfect sages; there are only people who are attempting, together, to learn more than they know now” (Freire, 2003, p. 90). Dialogue also requires faith in the potential of all human beings to “make and remake the world.” Even when oppressive and demeaning forces undermine human will and power to act upon the world, dialoguers retain their faith in the transformation project. Such faith, then, is intimately tied to hope for a more just world and more just relationships with others. “Hopelessness is a form of silence, of denying the world and fleeing from it” (Freire, 2003, p. 91). Freire sees this hope as more than an intrapsychic and passive stance; it emerges out of the struggle “in communion with others” and strong belief in the fruitfulness of the struggle.

Bohm’s and Buber’s influences become crucial in cultivating the actual communicative practice of dialogue. Bohm (1980) conceptualized dialogue as a glue to challenge social fragmentation and proposed four building blocks (Weiler, 1994). *Suspending judgments* refers to developing an openness to others and their perspectives. Judgments, prejudices, likes, and dislikes are seen as filters disrupting connectivity in communication. Through an awareness of these filters, which may itself develop continually in dialogue, one can be

more mindful and intentional in engagement. Suspending judgment allows *deep listening*, which calls to be present for and with others and to diminish inner chatter or preoccupations. Such chatter may be as simple as thinking about another subject or feeling anxious in the interaction itself. It is distracting; it draws attention away from the speaker and the interaction and may also enter the interaction as an interruption of the speaker or a diversion of the conversation. Suspending judgments and deep listening together enable recognition and validation of others' sharing and experiences without the pressure of agreement (Nagda, Gurin, Sorensen, & Wong (Lau), 2013). Next, *identifying assumptions* refers to understanding what informs our perspectives and the meaning we make of our experiences or observations of others. Lastly, *reflection and inquiry* involve interactants in making sense of the exchanges unfolding and asking questions to continue the dialogue. Such inquiry may delve into the micro-level impact of experiences, the macro-level connection to social systems of privilege and oppression, or the mezzo-level dynamics of dialogue unfolding in the group. Thus identifying assumptions and reflection and inquiry can encourage deeper understanding through insights and new questions (Nagda et al., 2013).

Although neither Buber (1970) nor Bohm (1980) were explicitly concerned with dialogue as a social justice project, their insights on dialogue-in-relationship are helpful in contrasting dialogue from other forms of discourses, such as debate and discussion (Chasin et al., 1996; Nagda & Gurin, 2007). Debate seeks to deduce the one truth supported by a clear logic. Metaphorically speaking, debate may be seen as a straight line, from point A to point B. Argument is prime in debates, so although opponents/participants may listen to each other, they do so to undercut the other's perspective and to advocate for one's own point of view. Discussion, on the other hand, allows multiple perspectives, but these opinions, arguments, or points of view may not necessarily be grounded in lived experiences or connected to each other. Discussion may be envisioned as a circle of voices, one after another, sometimes connecting with what has been said before and sometimes not. In discussion, speaking is prime, and although participants do listen, it may be only to wait for their turn to speak. Dialogue allows multiple truths and stresses responsive listening and speaking for personal and social inquiry. Dialogue may be imagined as a spiral, denoting movement with the inclusion of multiple voices that both deepens interpersonal understanding and expands critical inquiry. Dialogue is exploratory and creative, while debate is definitive (also see Isaacs, 1999; Nagda, Gurin, Rodriguez, & Maxwell, 2008).

THEORY, PRACTICE, AND RESEARCH ON CRITICAL-DIALOGIC INTERGROUP DIALOGUE

In discussing the foundations of intergroup dialogue, I have drawn on progressive traditions in the psychology of intergroup contact, conscientization, dialogic education and social justice education, and dialogic communication. The theme of bridging relations—bringing diverse people together, honoring lived experiences and critically analyzing diverse social realities, and fostering communication as the nexus of connection—is resonant across these foundations. In the rest of the chapter, I describe the theory, practice, and research on the critical-dialogic intergroup dialogue that embraces the vision and challenge of bridging relationships across differences. We have referred to our model of intergroup dialogue as a critical-dialogic model to capture its simultaneous focus on the *dialogic*—building relationships across different identity groups—as well as the *critical*—developing complex understanding about these very differences in interests, identities, and inequalities so as to

mobilize individual and collective agency for making a difference (see Nagda, 2006; Nagda & Gurin, 2013; Zúñiga et al., 2014). The critical–dialogic model of intergroup dialogue is a mezzo-level, social justice group intervention to fulfill three goals:

- to improve intergroup relationships *across* social identities and inequalities
- to increase intergroup understanding *about* social injustices on the individual, group, and societal levels
- to enhance capacity for intergroup action *for* individual and collective change efforts

A Theory of Change in Critical–Dialogic Intergroup Dialogue

A theory of change specifies the mechanisms for connecting the intergroup dialogue intervention to the three sets of outcomes—intergroup understanding, intergroup relationships, and intergroup action. Social psychological research on intergroup contact has focused on cognitive and affective psychological processes *within* individuals that help explain the impact of intervention on outcomes (Dovidio et al., 2004; Pettigrew & Tropp, 2011; Stephan, 2008). Drawing from ongoing practice in facilitating intergroup dialogues and training facilitators, Nagda (2006) theorized an additional kind of process—communication processes—to help capture the power of communicative interactions that happen *among* individual participants in the dialogue milieu. The theoretical model (see Figure 22.1) shows that intergroup dialogue pedagogy (content learning, structured interactions, and facilitative guidance) fosters four distinct communication processes that in turn affect the affective and cognitive

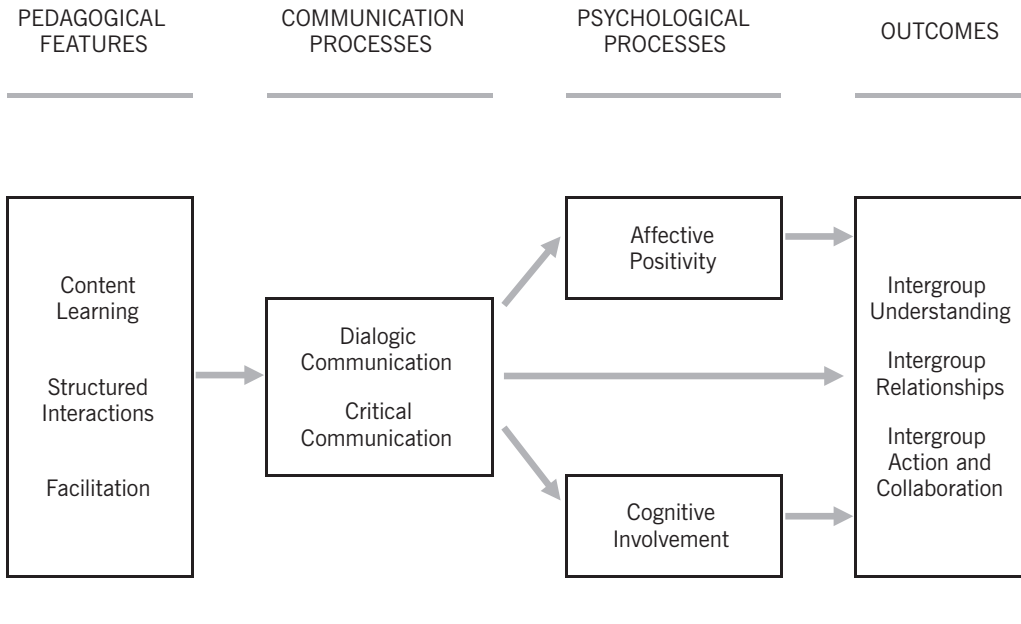


FIGURE 22.1. A critical–dialogic theoretical framework of intergroup dialogue. From Nagda, Gurin, Sorensen, and Wong (Lau) (2013). Copyright © 2013 Russell Sage Foundation. Adapted by permission.

psychological processes. Together, the communication and psychological processes affect the three sets of outcomes. A detailed description of the theoretical model is presented elsewhere (see Nagda et al., 2013), but I describe the major components below.

Pedagogical Features

A metaphor of a container is appropriate in describing the structural and pedagogical design of intergroup dialogue. IGD adheres to Allport's (1954) conditions for positive intergroup contact but also conceptualizes them through a social justice lens. For example, equality is created within the contact situation by having equal numbers of participants from the different identity groups in the dialogue and having co-facilitators who represent the groups in dialogue. Facilitators, in addition to institutional norms that support active engagement of diversity, also provide authority sanction.

Because bridging relationships for diversity and social justice is about explicitly surfacing differences and conflicts (Garvin & Reed, 1994), Allport's (1954) conditions of recognizing common humanity and common goals are modified in intergroup dialogue. It was believed that common humanity would be achievable by providing opportunities for interactants to get to know each other on a personal level. Pettigrew (1998) refined this further to an interactional process of friendship potential, which is developing close affective ties across similarities. In intergroup dialogue, however, Nagda and colleagues (2004) operationalized this as a motivation to bridge differences that involve close relationships specifically based on explicit sharing and learning about social identities and differences. Finally, intergroup dialogues do focus on the common goal of social justice through individual and collective action, but "we do not all have to do the same thing in the same way. Instead, we must support each other's efforts, realizing that they are all part of the larger enterprise of bringing about social change" (Collins, 2013, p. 609). Collective action, therefore, can be both intragroup- and intergroup-oriented. In addition to these conditions, an intentional pedagogy—content, structured interactions and facilitation—fosters meaningful learning in the dialogues.

Content involves learning and reading information, as well as written reflections. Readings may include theoretical, conceptual, empirical, and narrative material about social identities, dynamics on power, privilege, and oppression, and actions for social change. Case studies and artistic pieces, such as poems, may also supplement content. Most of this content is used as preparation for particular dialogue sessions, and some (such as conceptual organizers or definitions) may be presented in the session itself to ground reflection, conversation, and sense making. Written assignments encourage use of these informational sources to triangulate with the participants' own experiences inside and outside the group.

Structured interactions engage participants in active and experiential learning. Because participants come from diverse backgrounds, these learning activities serve as a common reference point and springboard for individual reflection and collective dialogue about similar and different experiences of the activity itself and connections to issues outside the group. I describe illustrative structured activities in the four-stage practice model later in the chapter.

Facilitative guidance is crucial to harness the learning and change potential of relationships. Facilitators, as group workers, hold the dialogue container and also foster the individual reflective learning and the social, interactive group development among participants within the container (Coyle, 1935; Steinberg, 2010). Facilitators are guides, not teachers, and are expected to be a part of the learning process, not apart from the participants. "Consistent with its democratic foundation, the worker does *with* the group rather than

for the group or to the group” (Alissi, 2001, p. 5). They may share their experiences and perspectives to convey a stance of learning with participants, to join in support of particular participant(s), or to illuminate differences constructively. Such “use of self” is done to stimulate further dialogue, inquiry, and interaction among participants but not to impose their views on the participants or undermine others. While facilitators implement specific educational modules and structured interactions, they attend to the processual elements of learning and do not simply lead participants procedurally through activities. They model listening and empathic connection and use inquiry to help participants derive learning from these structured interactions through individual reflection and dialogue about differences and similarities of experiences and perspectives and through dialogue about the interactional and identity dynamics emergent within the container. Facilitators also intervene when they see destructive dynamics of dominance playing out in the group, such as monopolization of participation time by certain individuals or members of particular groups or when dialogue turns into debate (see Nagda & Maxwell, 2011, for a more detailed description of intergroup dialogue facilitation).

Communication Processes

The heart of intergroup dialogue, like social group work in general, is in the communicative interactions among participants (Alissi, 2001; Breton, 2012; Garvin et al., 2004; Toseland et al., 2004). Actualizing the emphasis on dialogic and relational ethics beyond individual virtues, two sets of communication processes define intergroup dialogue—dialogic and critical communication processes (Nagda, 2006; Nagda & Gurin, 2013; Nagda et al., 2013). These processes, fostered by the intergroup dialogue pedagogy described above, are expected to meaningfully engage participants from the different identity groups in the co-learning situation. *Dialogic communication* comprises appreciating difference (listening to and learning from others, asking questions) and engaging self (sharing one’s own stories). Together, the two dialogic processes connote mutuality and reciprocity in the interaction to counter a voyeuristic focus on the “other” or a narcissistic preoccupation with the “self.” Dialogic processes, while acknowledging difference and helping bridge self–other relations, may still occur without an explicit consideration of societal context of dominance and subordination. Thus *critical communication* enunciates the lens of social justice in construing critical reflection (introspections and collective reflection about how power and privilege influence identities, perceptions, and interactions) and alliance building (working through difference and conflicts and talking together about collaborating on social actions). Together, the two critical communication processes help bridge social and critical awareness to collaborative action. These communication processes—interactions that happen *among* participants—are theorized to affect the cognitive and affective psychological processes *within* individual participants and to lead to outcomes of intergroup understanding, intergroup relations, and intergroup action (Nagda et al., 2013; Sorensen, Nagda, Gurin, & Maxwell, 2009).

Cognitive and Affective Psychological Processes

Gitterman (2003) stated that “members must experience their group as a distributively fair and safe place before they will undertake effective collective action. Making a difference in one’s group is a prerequisite for attempting to make a difference in the larger environment” (p. 27). The conception of “safe place” is sometimes controversial in diversity settings and considered to be a manifestation of dominant group privilege (Arao & Clemens, 2013).

Yet the feeling of being included, engaged, and making a difference in the group that may be part of safety applies as well to intergroup dialogue participants. The psychological processes of *cognitive involvement* and *affective positivity* reflect the internal states of effortful thinking and meaningful relating in intergroup dialogue. Through its pedagogy and communication processes, IGD fosters cognitive involvement by encouraging students to consider multiple perspectives, engage with social identities, and think in a complex way about issues and analytically about society. Similarly, the container created for intergroup engagement and specific attention to fostering communication about sensitive issues not often addressed in most settings aims to foster affective positivity through comfort (and confidence) in talking with other groups, meaningful discussion and sharing of feelings and problems, and positive emotions in the interactions. In other words, the learning environment and communicative interactions foster engagement that is highly intellectual *and* deeply personal.

Yeakley (1998), in a qualitative study of change processes in intergroup contact, found that personal storytelling (in a listening environment) was often the difference between positive and negative contact experiences. Furthermore, the quality and depth of engagement influenced the kinds of outcomes derived from the contact. Small talk, devoid of personal sharing, increased comfort and discussion of only common interests fostered friendship-like connections. However, if the personal sharing included discussion of differences and identities, there was increased understanding of multiple perspectives and of inequalities. Alternatively, if personal stories, once shared, are not received well, students may feel hurt, judged, and resentful or disconnected from others. Keehn (2014) similarly found that identity-based personal storytelling served as a point of transformative connection to others, sometimes through the “head” and sometimes through the “heart,” for students in social justice education courses: “Listening to stories allows students to connect to the course material cognitively and affectively and helps information become ‘real’ to participants” (p. xii).

Personal storytelling about lives in conflict is the cornerstone of the narrative approach in Jewish–Palestinian dialogues in Israel. Earlier approaches in these dialogues were either human-relations-oriented coexistence models that focused heavily on personal identities and similarities or social identity–informed confrontational approaches that leaned greatly toward difference and power inequities (Hammack & Pilecki, 2015; Maoz, 2011). The former reproduced status quo dynamics favoring Israelis within the encounters and delegitimized Palestinian concerns about nationality. The latter reversed these dynamics in favor of Palestinian Arabs’ narratives of history and status, strode a fine line between confrontation and verbal violence, and alienated Israeli participants (Maoz, 2011). The narrative model combines features of the coexistence and confrontational models and uses personal storytelling as a medium for learning about issues affecting the Israeli–Palestinian conflict and building affective ties. “Encountering the experience and suffering of the other through story-telling is seen as enabling conflicting groups to create intergroup trust and compassion by re-humanizing, and constructing a more complex image of, each other” (Maoz, 2011, p. 120). Much like the critical–dialogic model of intergroup dialogue, the narrative approach bridges affective interpersonal and intergroup interactions and builds understanding of the complexity of power inequalities and conflicts.

I have described in more detail elsewhere the social science and education research that supports how psychological processes mediate the impact of intergroup dialogue pedagogy and communication processes on the three sets of outcomes (see Nagda, et al., 2013). I describe these overall outcomes next.

Outcomes

Three sets of outcomes, directly aligned with the goals stated earlier, typify the critical-dialogic model of intergroup dialogue. First, the outcomes of improving intergroup relations—*intergroup empathy* and *motivation to bridge differences*—correspond directly to the call for social competence (Allen, 2016) and relational ethics (Clements, 2012) discussed earlier. Personal storytelling and meaningful discussions about social issues in which participants also exercise intentional speaking and active listening are likely to increase their care for and trust with each other and recognition of each other's humanity and vulnerability (see the "Testimonials" activity described later). Intergroup empathy is an emotional form of empathy that recognizes identity and status in its connection (Nagda, 2006; Wong (Lau) et al., 2013). It occurs when an individual responds to the feelings of a member of a social group by feeling what the other person feels (parallel empathy) or by reacting emotionally to the experiences of the other person (reactive empathy; Stephan & Findlay, 1999). Motivation to bridge differences refers to identity-based knowledge and sharing that is one of the cornerstones of intergroup dialogue. It involves reciprocal exchanges that seek connection through differences and similarities rather than being divided by differences (see "Caucus/Fishbowl" activity described later).

Second, the outcomes of intergroup understanding—*understanding structural inequality* and *attitudes toward diversity*—help connect the micro-level appreciation of individual experiences to the macro-level structures of inequality and support for institutional diversity efforts. IGD pedagogy that also includes content learning and structured interactions about social inequalities (see, e.g., the "Web of Oppression" activity described later) complements the more personal storytelling and collective sense making. Conceptual organizers and definitions help give language to students' experiences and serve as a way to see the diversity of experiences and the common linkages to structural phenomena. Understanding structural inequality refers to contextualizing differences and inequalities in the historical, structural, and institutional arenas and not simply as a matter of individual causation, choice, or deficiency. Attitudes toward diversity refer to support for the campus and institutional efforts in promoting engagement with diversity. This is particularly important for intergroup (e.g., racial and gender) climate on campuses and students' sense of belonging, especially for students from less privileged groups (see the "Introduction" activity described later). Thus the concept of diversity is more than a distanced acknowledgment of representational or demographic diversity; it includes macro-level understandings of inequalities and support for organizational and institutional conditions that can foster active engagement with diverse others.

Third, outcomes of intergroup actions—*self-directed prejudice reduction*, *other-directed diversity promotion*, *collaborative actions* and *post-college commitments*—connect dialogue to action and change. Intergroup dialogue involves participants in thinking, talking, and acting for social justice to solve social problems. IGD promotes both individual actions and intergroup collaboration across differences (see the "Intergroup Collaboration Project" activity discussed later). At the individual level, self-directed actions involve educating oneself about other groups, becoming more mindful about one's prejudices and biases and unlearning them, and becoming conscious of the impact of one's behaviors on others. Other-directed actions involve educating others about diversity issues, supporting others' socially just behaviors, and interrupting acts of bias or ignorance among others. Intergroup collaboration involves joining an action group and participating in community-based collective actions. Post-college commitments refers to the desire of students to become engaged

in their communities to promote intergroup understanding and participate in community organizing.

I turn next to the four-stage practice model of intergroup dialogue with a richer description of specific sessions and activities to illustrate how the theoretical model described above comes alive in practice.¹

A FOUR-STAGE PRACTICE MODEL FOR CRITICAL-DIALOGIC INTERGROUP DIALOGUE

Because a critical-dialogic model of intergroup dialogue mobilizes group processes for social justice outcomes, we use a group development framework that attends continually to relationship building and understanding of social identity and inequality to facilitate social action. I, together with other colleagues, have described the practice model of intergroup dialogue as a four-stage model elsewhere (Nagda et al., 1999; Nagda & Gurin, 2013; Zúñiga et al., 2002, 2007). The four-stage model (see Figure 22.2) parallels the Just Practice framework developed in social work (Finn & Jacobson, 2003) and applied to social justice group work: establishing an environment of mutual support and expectation; engaging with questions of power, difference and inequality; making connections among the personal, political, cultural and historical; and taking action and accompanying the process (see Finn, Jacobson & Campana, 2004; Jacobson & Rugeley, 2007). Below, I describe select activities to illustrate how college-based intergroup dialogues enable a change process for engaging diversity, developing social competence, and bridging relationships by moving beyond an intrapsychic and intragroup approach to an intergroup approach that builds self-other relations, connects micro to macro issues, and links dialogue to action. These activities can be easily adapted to organizational and community settings.



FIGURE 22.2. A four-stage practice model of critical-dialogic intergroup dialogue.

Stage 1: Group Beginnings—Forming and Building Relationships

IGD starts with setting the context for learning about identities, differences, and inequalities. Because IGD is a sustained intervention to bridge differences in estranged relationships, a major focus of the first stage (two to three sessions total) is to prepare participants to value relational learning and engaging differences. Facilitators guide participants in both knowledge building to understand the distinctions among discursive modalities of debate and dialogue and dialogue skill building.

An opening introduction may involve a round-robin sharing of participant names, preferred gender pronouns, and experiences of diversity on the campus or community. Participants often share that the community feels divided, that they see diversity but have not actively engaged with diversity, or that their learning about diversity has so far been theoretical and not experiential. A second round asks participants to share something that they have on their person and its meaning for them. The personal items may be their driver's licenses or other identification cards, a piece of jewelry, a book, pictures on their cell phones, and so on. These low-risk introductions help reveal a little bit beyond the surface about each student and the diversity present in the group, begin a norm of storytelling and listening, and give an experience of what inclusivity and reciprocity in learning looks like.

Another important activity to help set the context for learning through bridging relationships is a role play of debate and dialogue to highlight the differences among these modes of engagement (see Nagda & Gurin, 2007, for more detail). After dividing the group into two, each group takes on a hypothetical issue (such as, "National community service should be required of all high school graduates before beginning college") to plan their role play. The groups come up with their own interpretations of what debate looks like or what dialogue looks like and then act it out for the whole group. Facilitators help debrief these two role plays, inquiring about the feelings associated for the participants in the two role plays, the verbal and nonverbal behaviors, and the spoken and unspoken scripts. Participants usually comment on debate role plays with two opposing sides arguing forcefully but not grounded in personal experiences, talking over others and interrupting behaviors, and some "fight," "flight," or "freeze" behaviors—all to do with divisive relationships. In the dialogue role plays, participants comment about the inclusion of all voices, more grounding in personal experiences, encouragement to elaborate, questions of clarification and curiosity for understanding, and a rethinking of perspectives after listening to the diversity of perspectives—all to do with building bridges of understanding. Through such active engagement, participants have an embodied feeling of different communication modalities, often reminding them of real-life experiences outside of the dialogue group. The stark differences sometimes illuminate the taken-for-granted ways of conversing and set an aspiration for a group commitment to engage in dialogue and relational learning:

The behaviors we practiced in role-playing both a debate and a dialogue helped me get what dialogue means right at the beginning of the course. . . . From then on, we knew when we were slipping into debate because we understood what it looks and feels like. (White woman, race dialogue; quoted in Nagda & Gurin, 2013, p. 62)

In another two-part activity that begins to build dialogue skills, participants in dyads take turns in intentfully speaking and actively listening to each other's hopes and fears about intergroup dialogue. While one participant shares, the partner listens attentively but nonverbally, and then verbally paraphrases what he or she has heard. Some participants may voice feelings underlying their dyadic partner's sharing, thus creating a sense of emotional

empathy. Then they switch roles. In debriefing the activity, facilitators ask for general and specific observations from this exercise. Participants often convey that they did not realize how little they listened to others or felt truly listened to:

Being in the dialogue made me a better listener. Active listening is more than just seeming to be interested in what the speaker is saying; rather it is being attentive to the speaker in every way—verbally and non-verbally. Before this class I would find my mind wandering off after listening to someone for a couple of minutes. Now I can really focus and listen in depth. (Woman of color, race dialogue; quoted in Nagda & Gurin, 2013, p. 63)

Participants also remark that their everyday conversations with family, friends, and acquaintances are fast-on-the-go, “tweet-sized,” or that they are just eager to talk without listening to others. Some aspirations participants have in being in intergroup dialogue are to be able to talk *with* others about social issues rather than being talked *at*, to apply the theoretical learning from other classes to dialogues with peers, to find support with others, and to take risks in having conversations that they have yearned for. Participants also see how it is possible to hold differences through mutual validation rather than feeling pressured to agree or feel the same way. Most importantly, the activity illuminates that members of the different groups share some fears and hopes but also come with different motivations and concerns about engaging with strangers.

The culmination of the first stage involves participants in articulating guidelines for group engagement. Facilitators ask participants about how they would like to engage with each other and how the group as a whole can support their hopes and address their fears. Guidelines that commonly emerge in the group include active listening, using “I” statements, not assuming but asking clarification questions, allowing risk taking, seeking to understand, connecting to each others’ perspectives, and recognizing how power and privilege play out in the group.

Stage 2: Exploring Differences and Commonalities of Experience

Because the intergroup nature of dialogue seeks to situate the commonalities and differences of everyday, micro-level lived experiences in larger macro-level social arrangements, the second stage (four to five sessions total) starts framing issues and experiences in terms of social identities, sociocultural differences, and social inequalities. Participants examine their lives through the *cycle of socialization* (Harro, 2013a), focusing on the influence of family, friends, peers, adults, social institutions, and the larger culture on their thoughts, perceptions, and behaviors concerning themselves and others. They read and discuss conceptual and informational material on prejudice, stereotypes, discrimination, power, privilege, and oppression.

The dyadic listening–speaking skills built in the first stage of the dialogue are now expanded to a small-group level. Participants are asked to share first how they see their lives through a personal identity wheel. They write down responses to questions about their personal hobbies, birth order, favorite food, favorite book, a motto they live by, and so on. They take turns sharing this in small groups of four to five participants and learn more about each other, their likes and dislikes. Next, they map their lives on a social identity wheel, which asks them first to write down their identities in different social groups—race, ethnicity, gender, class, sexuality, age, national origin, ability status, religion/spirituality, and so on. Then they consider questions such as: “Which identities do I think about most

often?”, “Which identities are most important to the way I think about myself?”, “Which identities do I not usually think about?”, and “Which identities do I want to learn more about?” Again, in small groups, participants share their identities, as well as responses to the questions grounded in personal experiences and stories. Participants often say that they think more about identities in which they are marginalized and less about identities in which they have privileges. Even though participants may share different identities that are important to them, they find commonality in the role and meaning of those specific identities in their lives. In the collective reflection and dialogue, facilitators ask participants about their thoughts and feelings on conceptualizing themselves through the personal and social identity wheels and how the two may relate. They also ask participants why certain identities may be more important than others to them and their peers. This inquiry helps students see how their personal hobbies and qualities may indeed be influenced by their social identities. Conversely, even when social group memberships are shared, there can be heterogeneity in how each person expresses those identities.

In a subsequent session, these understandings of personal and social identities become more focused on socialization experiences in the Testimonials activity. For example, in a gender dialogue, participants prepare a narrative about their socialization experiences related to gender through family, peers, adults, social institutions, and the larger societal culture. They recount critical incidents and experiences that shaped their gender identities and gender expression, points in their lives where they became aware of gender differences, privilege, and oppression, and so on. In the dialogue group, facilitators invite each person to take turns sharing their testimonials and to listen attentively to others’ narratives. Facilitators also ask participants to refrain from asking questions when someone is speaking; instead, participants use index cards to write any thoughts and questions that come up while others are speaking. The intentional set-up of this testimonial session allows deeper inquiry to emerge from the active listening of multiple testimonials as opposed to just one. The reciprocal self-disclosure and listening, inquiry to understand experiences more fully, and finding points of connection through both commonalities and differences serve to foster intergroup empathy among students. The quality of such empathy is a deeper appreciation of others’ lives in the larger context (intergroup and emotional), beyond simply taking another’s perspective (interpersonal and cognitive). A participant commented on the pivotal quality of sharing testimonials:

I can say that all of us have deeper understandings of our identities. That has come partly from readings but it began very early in the testimonials when we saw how personal identity and social identity were different. The testimonials when everyone shared about their own lives and how their identities were formed and affected them, that was a turning point for me. I could see how identity is part of everyone’s make-up. (Man of color, race dialogue; quoted in Nagda & Gurin, 2013, p. 65)

In the next session, to enlarge the frame of individual experience in the social structure to a group-based experience, participants dialogue in intragroup caucuses with those who share their particular social identity. In an interracial dialogue, for example, participants of color, bi/multiracial participants, and white participants meet in separate groups to dialogue specifically about the meaning of their identity, the personal impact of privilege and oppression on their everyday lives on campus and in larger society, and ways in which they cope with or address issues of privilege and oppression. These intragroup conversations then continue in a fishbowl format in which participants from one identity group dialogue

in an inner circle about their learning from the caucus groups: How did it feel to have the in-group conversation? What are the commonalities in how we experience privilege and/or oppression? How does our privilege/oppression affect our relations with the other group(s)? Participants in the outer circle listen attentively, without interruption. Later, participants from the outer circle are invited to paraphrase one thing each of them heard, and the participants in the inner circle listen without responding. This format is repeated until all caucuses have had a chance to share and everybody has also had a chance to listen. In debriefing the caucus group/fishbowl experience, facilitators ask for observations and insights. Some participants, usually from the dominant group, share their discomfort in being separated from the whole dialogue group and talking with people similar to themselves, especially about taking ownership of privilege. Participants from disadvantaged groups usually talk about being recognized and validated without explanation as well as a sense of safety and connection in the caucus groups. While many may perceive identity-based caucuses as a breach in the interpersonal and group cohesion developing in the dialogue group, such an explicit asymmetric dynamic becomes an important learning moment. Facilitators ask participants to name their feelings, perhaps taking a moment to write them down, and then inquire about why this dynamic exists. The dialogue can then lead to a critical analysis of white participants' fears, for example, of facing and owning white privilege in interracial settings and a threat to the sense of moral goodness and to a parallel but opposite sense of empowerment of the participants of color and bi/multiracial participants in talking about racial oppression as a systemic issue, not an individual deficiency (Sue, 2015).

The testimonials and intragroup conversations reflect what Breton (2012) identifies as personal data shared through storytelling. The personal stories build recognition of similar and differential impact of systems of privilege and oppression on individual and group life. These conversations allow for bonding experiences across individuals and in intragroup caucuses, as well as bridging experiences between the different identity groups. The next activity, the *web of oppression*, links the personal data to objective information by continuing to contextualize the emerging individual, intragroup, and intergroup experiences within structures of power and privilege. In preparation for this session, facilitators build a preconstructed web with packets of cards attached throughout the web. Each packet of cards represents a particular institution that the participant interacts with or is likely to do so directly or indirectly (e.g., education, media, health care, university, legal system). The name of the particular institution is written on the face card of each packet, which also includes statistics and information that highlight the racial or gender inequities and disparities that exist within these institutions. For example, the education packet may show racial disparities in access to higher education; student, staff, and faculty demographics on campus; graduation rates; and so on. To start, facilitators ask all participants to hold the web and invite them to take turns in picking an institution, to share any personal examples of privilege and oppression related to the particular institution, and then read the associated information on the cards. The sequential elucidation of inequalities existing within each institution reveals the pervasiveness of the disparities and the interconnections among the institutions. A participant commented on coming to understand structural and institutional dimensions of inequality:

For the first time I grasped the disadvantages I face as a woman. Sexism is so institutionalized that I did not realize that a lot of my everyday activities and relationships with men are constructed in a manner in which they dominate. (White woman, gender dialogue; quoted in Nagda & Gurin, 2013, p. 66)

In addition to the web being a visual illustration of structural inequality, participants also report on the tactile nature of the activity. Holding the web for an extended period of time can be exhausting; some participants want to drop it completely while others adjust how they hold it without losing their grip on it. Toward the end of the session, facilitators may pose questions such as: How do all these institutions interconnect to structure inequality? How do we redress inequality? How do we challenge structural inequality? Some participants may say that we just let go of the web, while others may say that that is never possible and that inequality is not something anyone can walk away from. Participants in the more privileged group sometimes share their growing guilt and not knowing what to do. Participants from disadvantaged backgrounds sometimes share their anger about the pervasiveness of inequality and perhaps a sense of despair and hopelessness. Facilitators often say that we are all affected by inequalities, though differently, and that letting go of the web out of despair or guilt only maintains the system. Participants also learn that just as causes of inequalities are interconnected, as illustrated in the web, reducing inequalities will also require action in the many interconnected institutional arenas in the web.

Stage 3: Exploring and Dialoguing about Hot Topics

The first two stages lay a strong foundation for dialogic engagement and critical analysis of individual, intragroup, and intergroup experiences and structural inequality. While some of these experiences and realities are connected to personal and everyday issues, the third stage (two to three sessions total) brings current social issues to the forefront. Participants critically analyze controversial and conflictual issues through the lenses of identities and inequalities, see how issues such as interracial dating, micro-aggressions, immigration, safety on campus, gender violence, prison industrial complex, and minimum wage are larger manifestations of the challenges and possibilities being explored in intergroup dialogue.

A variety of different learning activities are used to stimulate the dialogue, especially to uncover multiple perspectives. To do this, ample time is needed for unpacking differences and conflicts, mapping the historical and structural forces related to a particular issue, and offering opportunities for continued learning and/or challenging the inequalities embedded in the issues. One widely used activity is the *gallery walk* (see Zúñiga et al., 2007). On the issue of gender and media, for example, participants are asked to bring advertisements or representations of gender from media and other sources that convey stereotypical/patriarchal expressions and positive expressions of gender. The negative ones are posted on one side of the room and the positive ones on another side. The images may be supplemented with videos of advertisements or documentaries. Participants walk around silently and look at the images with care and reflect on the thoughts and feelings coming up for them. After the walk, facilitators invite students to share their reflections. How do the different images affect us similarly and differently? How does media perpetuate inequality? What are the economic, political, and social factors that perpetuate this inequality? What is the impact of these images in our everyday lives? How have we internalized these images? A collective reflection may also lead to thinking about strategies to intervene in both the personal impact of these images and in addressing media sources that perpetuate the messages of misogyny and patriarchy. Dialogues about controversial social issues help bridge the classroom learning to issues in the larger society. Participants see how issues of identity and difference are prevalent in their daily lives, whether they engage with them consciously or not:

Putting up those examples from magazines that showed so much sexism has stayed with me. I used to read those magazines at the gym without paying attention but now I go through them and point out how women are portrayed, men too, in sexist ways. I now understand the role of media in enforcing gender stereotypes. (White woman, gender dialogue; quoted in Nagda & Gurin, 2013, p. 69)

Stage 4: Action Planning and Collaboration

The final stage (two to three sessions total) connects dialogue and reflection to action, with the hope that bridging relationships can be translated to making a difference together outside of the dialogue group. Participants learn and talk about both individual and collective actions toward promoting diversity and justice. Harro's (2013b) *cycle of liberation* serves as a useful conceptual organizer to map out the self-empowerment, collaborative actions and cultural change strategies to promote social justice. A major learning activity is the Inter-group Collaboration Project (ICP). Usually, groups of four participants, equally drawn from the two identity groups, work together for about two-thirds of the academic term to design an action project to be implemented outside the classroom. A participant remarked on how the ICP helped connect dialogue to action:

Beyond learning how to engage in the formalities of dialogue, I also felt that the opportunity to collaborate on the ICP helped me grow. . . . What I found remarkable about the project was that it provided us an outlet to promote awareness on campus of different cultures and cultural issues. It is usually difficult to get others to listen, but the ICP gave us a way to affect some type of change. (White man, race dialogue; quoted in Nagda & Gurin, 2013, p. 71)

This extra-group project is aimed not only at the product and task level but also at the process of intergroup collaboration—from initial consideration of ideas and different kinds of leadership emerging to working through tensions and task allocation—through the lenses of social identities, privilege, and power. Each ICP team presents their projects and learning from both the collaborative process and actual action implementation. Following the idea of “undoing the web” developed in the previous stage, there is a collective reflection about the rewards and challenges of actions and collaborations, the ways in which the different projects together may have collective impact, and lessons to apply in the future. A participant articulated his developing insights on alliances for social change:

[It] requires much more than just laying down demands on a few issues. It takes full commitment and determination from all parties. Such alliances are formed out of desire and passion for bettering our world, not because of sympathy. Instead, these relationships should revolve around empathy. (Man of color, gender dialogue; quoted in Nagda & Gurin, 2013, p. 72)

As a culmination of the dialogue, participants offer affirmations of each other's contributions to the collective learning and share next steps to manifest their own personal and social responsibilities toward justice beyond the dialogue group. The affirmation activity (and the fourth stage as a whole) strengthens a sense of hope that Yalom (1995) has identified as crucial in group work. Our hope is that participants are passionate about bridging relationships and collective action, having built “confidence in oneself, confidence in the group, and confidence in one's role in making a difference” (Gitterman, 2003, pp. 28).

I turn next to research highlights from a field study that investigated both the effects of intergroup dialogue and the mechanism of change that account for these effects (based on the theory of change described earlier).

RESEARCH EVIDENCE FOR CRITICAL-DIALOGIC INTERGROUP DIALOGUE

The theoretical and practice models discussed above were tested in a mixed-methods field experiment at nine different universities and colleges in the United States (see Gurin et al., 2013, for a full description of the study, findings, and implications). The participants were undergraduate students who applied to be in intergroup dialogues and were randomly assigned to an intergroup dialogue group (on race/ethnicity or gender) and a wait list control group. There were 52 pairs of intergroup dialogues and control groups (26 race/ethnicity and 26 gender), with a total of 1,437 students.

Quantitative Study and Results

Students in both the intergroup dialogue and the control groups completed a pretest at the beginning of the term of the dialogues, a posttest at the end of the term, and a post-posttest a year after the end of the term. In addition to demographic questions, these quantitative surveys included measures pertaining to the psychological processes and outcomes and the pedagogy and communication processes (for the dialogue students only). The random assignment of students to the dialogue and control groups was essential to be able to attribute causal effect to intergroup dialogue if the dialogue students showed significantly greater change compared with the control group on the different attributes.

The study investigated two major questions. First, what were the effects of intergroup dialogue? Pretest and posttest comparisons revealed a robust effect of intergroup dialogue on 20 of the 24 measures of psychological processes and outcomes of intergroup understanding (understanding of structural causes of group-based inequalities), positive intergroup relationships (intergroup empathy and motivation to bridge difference), and intergroup collaboration (confidence and frequency of individual actions, educating others, and collaborative action). These results are consistent for both the race/ethnicity and gender dialogues, as well as across student demographic groups (women of color, men of color, white women, and white men). Pretest and post-posttest (a year later) comparisons revealed a robust, longitudinal effect on 21 of the 24 measures.

Second, what processes produce these effects? Structural equation modeling tested and supported the theoretical model. As predicted, there was a significant direct effect of intergroup dialogue pedagogy (content, structured interaction, and facilitation) on the critical-dialogic communication processes (engaging self, appreciating difference, critical reflection, and alliance building). Both pedagogy and communication processes had statistically significant direct effects on the change in affective and cognitive psychological processes. The cognitive psychological processes were statistically connected to outcomes of understanding structural inequality and intergroup action, and the affective psychological processes were connected to outcomes of intergroup empathy and intergroup action. Communication processes were also statistically connected to outcomes of understanding structural inequality and intergroup action. Most strikingly, looking at outcomes a year later, only the communication processes, not the psychological processes, show a sustained and statistically significant direct effect on all three outcomes (see Sorensen et al., 2013, for more details).

Qualitative Study and Results

The qualitative aspect of the study aimed to gain an in-depth understanding of intergroup dialogue, especially the connection between pedagogy and the communication processes and relational outcomes. Final papers from the dialogue students reflecting on their learning ($n = 720$) were content analyzed. The analyses showed a distinction between relational (or dialogic) empathy and critical empathy, a distinction not available in the quantitative survey data. Dialogic empathy, which can be cognitive and affective, is akin to interpersonal empathy and does not specify any marker of identity difference (Nagda, 2006). Critical empathy, on the other hand, acknowledges an influence of group identity and/or positionality (dominant–subordinated status) in the empathic connection and may be conceived of as intergroup empathy (see Nagda, 2006; Wong (Lau) et al., 2013).

An intensive study of 10 race/ethnicity and 10 gender intergroup dialogues involved videotaping three dialogue sessions (early, middle, and late) and postdialogue interviews of the students ($n = 240$). The videotapes were coded for student and facilitator communicative behaviors, and the papers were coded for pedagogical activities and communication processes. Coding and analysis of videotape data allowed us to correlate facilitator dialogic and nondialogic behaviors with student dialogic and non-dialogic behaviors. Facilitator reflection/redirection and facilitator inquiry (both dialogic behaviors) were positively correlated with student attentiveness (listening), verbal initiative (speaking), openness, and inquiry. Facilitator inquiry was negatively correlated with students advancing their own perspectives separate from those of other students. Facilitator listening/support and advocacy were related to student debating (see Gurin, Meier, Nagda, & Gurin-Sands, 2013, for details). Content analyses of student interview data showed that specific structured activities—testimonials, caucus/fishbowl, and hot topics—cultivated dialogic communication processes (speaking as in engaging self and listening as in appreciating difference; see Hopkins & Domingue, 2015; Zúñiga, Mildred, Varghese, DeJong, & Keehn, 2012).

The Multi-University Intergroup Dialogue Research Project provided definitive evidence for the effectiveness of intergroup dialogue in improving intergroup relationships, increasing intergroup understanding, and enhancing intergroup collaboration. Furthermore, the findings provided insights into the mechanism of change in intergroup dialogue: the pedagogy of content learning, structured interactions, and facilitative guidance fosters intergroup communication processes and intrapersonal psychological processes that influence the outcomes.

FUTURE DIRECTIONS

Intergroup Dialogue Practice

The four-stage intergroup dialogue model represents important scaffolding of learning that attends to the communicative interactions and the cognitive and affective experiences. Future development can intentionally connect this rich dialogue group experience to a post-dialogue phase. Rose (2004) stressed the importance of transitioning from being-in-group to living-in-community, while others point to making learning relevant outside the group (i.e., extra-group; Breton, 2005). Barring this, or if left to chance, participants may revert back to their predialogue dispositions and behaviors. For example, Hammack (2006), in his research on Palestinian and Israeli youth participation in coexistence programs, found a

loss of effects postdialogue when the dialogue interventions on “cultural islands” (Bargal, 2008) ended and youth reassimilated into their home communities. If and when possible, I propose additional session(s) or a fifth stage to the IGD model focused on reintegration into community and working on social justice practice that can build on the intergroup collaboration and social justice commitments made at the end of the fourth stage. An intentional mapping of college and community agencies and programs that enable participants to join with others beyond their dialogue groups can facilitate continued learning and action. In colleges, one option would be to explore pathways for students to continue developing their knowledge, skills, and values for social change and social justice. Courses that situate social action within larger social movements and engage students in academic, experiential, and community-based change processes could be part of such a pathway (see Dudziak & Profitt, 2012, for an example). In community settings, postdialogue experiences may be linked to larger neighborhood development, immigrant integration, violence prevention and peace building, and restorative justice efforts. In both settings, intergroup dialogue alumni may become trained as facilitators and community intervenors, thus enabling them to put their social justice commitments into action (see, e.g., Lensen, Chesler & Brown, 2012; Nagda, Timbang, Fulmer, & Tran, 2011).

In college-based IGDs, the evidence points to significant effects in bridging relationships, understood broadly. Allen (2016) identifies two other kinds of ties: bonding ties (discussed earlier) and vertical ties that connect lay people to decision makers and policy makers. The intragroup caucuses in IGDs can foster more bonding ties in the service of social justice as opposed to simply maintaining group boundaries. For example, intragroup caucuses may be reconvened to debrief the intergroup collaboration projects, especially to examine how the dynamics of internalized dominance and internalized oppression, as well as alliance building, played out in the projects and the continuing responsibilities of participants from more privileged and less privileged groups postdialogue (see Pheterson, 1990). Furthermore, strengthening vertical ties that connect action projects and plans developed in intergroup dialogue to decision-making bodies in colleges and communities can also help make the dialogue experience more public. For example, young people participating in Summer Youth Dialogues in Detroit took their concerns to the state legislature, or participants in community dialogues presented action plans to local government bodies to address issues raised in community-wide study circles (McCoy & Scully, 2002).

Social Work Education

Social work education and professional development offer an important site for bridging the classroom efficacy and community responsibilities of intergroup dialogue. Drawing heavily from Freire’s fundamental proposition of *praxis*—conjoint action and reflection—IGD is about deepening social worker’s active engagement with difference, diversity, and social justice *and* connecting these experiences to social work practice. Freire (2003) cautions us that reflection without action is mere verbosity, and action without reflection is mere activism (presumably unproductive). Given the demonstrated success of IGDs in the undergraduate classroom, social workers can also benefit from IGD interventions as part of social work education and professional development. IGD, with its focus on bridging relationships, can help foster practice behaviors linked directly with two competencies—engaging with diversity and difference in practice and advancing human rights and social

and economic justice—as required by the Council on Social Work Education. Two additional considerations for professional practice are noteworthy. One, core IGD principles to engage differences and differentials can be helpful for practitioners interested in reflecting on and deepening their social justice practices. While the IGD model discussed in this chapter is embedded in the classroom and imagines connections to the larger community postdialogue, an IGD model for practitioners would be embedded in the community with direct applications to their ongoing professional practice. An important outcome would be for practitioners to define and develop a living social justice practice. Two, IGD principles can also be applied to social work supervision, which is a critical element in the preparation of new social workers and continued professional development of social workers. Similar to IGD interventions for practitioners, supervisors can participate in IGD learning to engage social, cultural, and power differences with their supervisees and in their organizational leadership roles. An additional dimension to this intervention would be learning social justice group work skills to strengthen group supervision work. Ultimately, be it in social work education and/or in community-based professional development, IGD-based learning can help to strengthen one's identity as a professional social worker and help one to use supervision effectively and practice a social justice and partnership ethos with clients, communities, organizations, and political systems.

Research and Theory Building

In developing the critical-dialogic theory of intergroup dialogue, I differentiated between individual-level psychological processes (occurring *within* individuals) and the social-interactive communication processes (occurring *among* individuals; Nagda, 2006). Thus continuing to identify and investigate social and contextual processes can deepen our understanding and practice of intergroup dialogues. For example, the intergroup dialogue theory discussed in this chapter focuses on positively oriented critical-dialogic communication processes. But dialogues across differences are difficult and not always connective. The work on microaggressions (Sue, 2015; Sue, Lin, Torino, Capodilupo & Rivera, 2009) and racial conversation stoppers (Markus & Moya, 2010; Narayan, 1998) speaks directly to ways in which participants disconnect in difficult conversations. Thus understanding the nature of disconnective and disengaging behaviors, which may silence, invalidate, or undermine fellow participants, can help elucidate anti-dialogue processes and their impact on bridging relationships (also see Yeakley, 1998). Assessing group climate—engagement, avoidance, and conflict—can also add to understanding the connective and disconnective processes, as well as positive and negative outcomes in intergroup dialogue (see Miles & Kivlighan, 2012).

Another area of further investigation concerns the facilitator and co-facilitator roles and dynamics. Although some research focuses on facilitators' identities (Maxwell, Chesler, & Nagda, 2011; Pennamon, 2014) and post-IGD experiences (Vasques Scalera, 2011), only two studies to date have looked specifically at facilitator relational behaviors (Evinger, 2014; Gurin, Meier, et al., 2013). Gurin, Meier, and colleagues (2013) document dialogic (reflection/redirection and inquiry) and nondialogic (support and listening, advancing their perspective) facilitator behaviors in 10- to 13-week dialogues, and Evinger (2014) documents facilitator knowledge, behaviors, and skills in multiple offerings of one-time dialogues. Both quantitative and qualitative investigation can help illuminate the impact of facilitators and co-facilitators on IGD processes and outcomes.

CONCLUSION

Danielle Allen (cited in Ramesh, 2013) asks, “Who helps us get better at bridging relationships?” This chapter conveys that one answer to the question is social group workers, of course! However, parallel to the critical–dialogic process of intergroup dialogue, this chapter has attempted to go beyond the answer and examined the underlying questions: What is the nature of bridging relationships? How do diversity and social competence work to bridge relationships? The critical–dialogic intergroup dialogue model is one example of an empirically tested social group work intervention that engages the power of relationships across differences as a milieu for critical personal and social inquiry, as well as individual and collective empowerment for social change. Together, the three sets of outcomes of intergroup dialogue—improving intergroup relations, increasing intergroup understanding, and enhancing intergroup action—texturize Allen’s proposition of bridging relationships for effective problem solving. Bridging relationships is more than just intergroup harmony or working with diverse others; rather, bridging relationships is an ever-evolving, integrative way of strengthening intergroup partnerships by engaging both difference *and* commonality, understanding both personal consequences *and* political causes of differences, and acting both individually *and* collectively for social change.

Intergroup dialogue is one group intervention that can actualize social work’s commitments to diverse democracies and social justice through the core of social work practice—building relationships. IGD’s pedagogy and emphasis on cultivating communicative interactions across differences provides a lens into the kinds of mindsets, relational ethics, and action capacities needed for social group work in diverse yet stratified democracies. The heart of sustained change in intergroup dialogue—the critical–dialogic communication processes—points especially to specific ways in which differences and injustices must be engaged to counter the reproduction of inequities in social interactions and to produce veritable alliances for democracy and social justice. Otherwise, as Burton and Welsh (2015) assert, micro-level processes of exclusion, such as “othering,” subordinate adaptation, and boundary maintenance continue to maintain inequality. They, like Allen (2016), draw on the promise of bridging capital to buffer the effects of exclusion; it can potentially prevent poverty and also mitigate the impact of poverty. “Social interactions are highly contingent on context, at both the individual and organizational levels, and changing the contexts in which these processes are operating has the potential to disrupt (or exacerbate) their effects” (Burton & Welsh, 2015, p. 9). Thus intergroup dialogues in educational and/or community settings can offer an alternative context that generates critical–dialogic communication processes as micro-level and mezzo-level processes of inclusion, not exclusion. Although intergroup dialogue may not directly affect the macro-level of exclusion, it can be a community-organizing intervention to help create conditions for individuals from diverse groups to convene together to be heard and to listen to multiple perspectives, to change the public discourse on inequalities, and to build capacity to participate in and influence decision-making and policy-making bodies.

NOTE

1. The practice model described here was developed as a standard curriculum implemented and evaluated as part of the Multi-University Intergroup Dialogue Research (MIGR) project. Nine colleges and universities collaborated on the project: Arizona State University, Occidental College,

Syracuse University, University of California San Diego, University of Maryland, College Park, University of Massachusetts at Amherst, University of Michigan, Ann Arbor, University of Texas at Austin, and University of Washington, Seattle.

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CHAPTER 23

Group Work in the Shadow of Mass Incarceration

REUBEN JONATHAN MILLER
DESMOND UPTON PATTON
JORGE DELVA

We live in strange and marvelous times. On the one hand, after reductions in the total inmate population in most years since 2009, the United States remains the world's leading jailer (Walmsley, 2014). On the other, policing and incarceration have returned to the public's imagination in a way that even careful students of the carceral state would never have thought possible less than a decade ago. From the reception of *Orange Is the New Black*, the Emmy- and Golden Globe-award-winning comedy series that webcasts the antics of Piper Kerman and her gang of convict friends, to President Barack Obama's historic visit to El Reno Federal Penitentiary, the prison has now been quite literally brought into our laptops and living rooms. This is with good reason.

It is by now well known that over 2 million inmates are held in U.S. jails and prisons. The collateral consequences of *mass incarceration*, the term commonly used to describe the historic growth of the U.S. prison system and the disproportionate incarceration of poor, largely black, but increasingly Latino U.S. residents since the mid 1970s, are well documented. We know, for example, that prisons punish the poor—half of jail inmates live on incomes at or below half of the U.S. poverty line (Wacquant, 2009)—and that the civic life of formerly incarcerated people is severely constrained. (See Burch, 2013, for a provocative treatise on the effect of mass incarceration on the civic life of communities with high rates of incarceration.) We also know that mass incarceration has had especially deleterious effects on poor people of color in the United States. Employment is hard to find for people “marked” by a felony record, but it is clear that the labor market is ostensibly closed to the black felon (Pager, 2008). Recent studies show that 1 in 9 black children have an incarcerated parent (Wakefield & Wildeman, 2013), nearly 1 in 2 black women has an incarcerated family member (Lee, McCormick, Hicken, & Wildeman, 2015), and Latino men are incarcerated at four times the rate of whites (Bonczar, 2003). Given the rapid expansion of

the carceral state in the last several decades, the cost and long-term effects of imprisonment on prisoners' communities, and especially on racially segregated neighborhoods composed disproportionately of poor blacks and Latinos, mass incarceration has become a widely acknowledged social problem in need of immediate and effective intervention (Travis, 2009).

Consequently, mass incarceration has drawn the attention of politicians on both sides of the political aisle. Pro-reform conservatives, such as Newt Gingrich, have joined with political progressives, such as Van Jones, to reverse the tide of mass incarceration, endeavoring to cut the prison population in half by 2030 (Gingrich & Earley, 2010; see also *www.Cut50.org*). Reform movements run by formerly incarcerated people have also emerged, as formerly incarcerated people attempt to lead the charge to address this most pressing issue of our time (see *www.justleadershipusa.org*). *Sesame Street* has even produced a series for children of incarcerated parents (*www.sesamestreet.org/parents/topicsandactivities/toolkits/incarceration*), demonstrating, more urgently than any statistic one could muster, the centrality of the prison to American public life.

While this renewed attention to issues of incarceration is warranted, a curious, and arguably more important phenomenon remains hidden in plain sight—the rise of a supervised society (see Miller, 2014; Miller & Alexander, 2016; Miller, Patton, & Williams, 2015). Over 600,000 inmates are released from jails and prisons each year (Carson & Sobel, 2014). They join nearly 5 million people under probation or parole supervision (Kaeble, Maruschak, & Bonczar, 2015), and a staggering 11.4 million cycling in and out of the nation's county jail facilities (Minton & Zeng, 2015); 19.8 million are estimated to have felony convictions (Shannon, Uggen, Thompson, Schnittker, & Massoglia, 2010)—a figure nearly 10 times the size of the U.S. prison population. Yet even these garish statistics are dwarfed by the 70 million people whom the FBI estimates to have criminal records (Bureau of Justice Statistics, 2014). These records are easily accessible through electronic background checks and have been used to exclude people from the labor market, housing, and access to state licensure (Heck, 2014; May, 1995).

Not only are formerly incarcerated people subject to unique forms of legal and regulatory exclusions, which severely limit their ability to participate in social, civic, and economic life (Miller & Alexander, 2016; Miller, Williams Miller, Zeleskov Djoric, & Patton, 2015), but they suffer from poor social, criminal justice, and health outcomes. Eighty percent qualify as indigents for the purposes of legal defense (Smith & DeFrancis, 1996). They disproportionately suffer from long-term illnesses and communicable diseases (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012), are chronically unemployed and face considerable barriers to their community integration upon discharge from jail or prison (Petersilia, 2009). It is therefore unsurprising that almost all former prisoners recidivate, and that they do so in short order. A recent study found that among 400,000 prisoners released across 30 states, nearly 80% were rearrested within 5 years for a new crime—half recidivated within 12 months and a third within just 6 (Durose, Cooper, & Snyder, 2014). More strikingly, the sample averaged 4.9 prior convictions and 10 arrests. Taken together, these figures demonstrate the pervasive and cyclical nature of arrest, incarceration, and successive rounds of reentry for the poor, and especially poor racial and ethnic minorities.

In the face of such seemingly intractable structural dilemmas, prisoner reentry, most often conceptualized as the process of leaving prison and returning to one's home community, is now recognized by leading academics and policy makers as a prescient social problem (Travis, 2009) and the community-based prisoner reentry program an important, if underexamined, organizational form. Despite this, we know little about the process of reentry, or whether the work of these organizations can sufficiently address the deep needs of

this population. Rather, the research on reentry largely addresses a series of technical questions about reentry's impact on recidivism (rearrest after a given period) or, in some cases, whether program participation leads to better social outcomes, such as housing stability or employment for its participations.

This chapter raises a series of questions about the dominant technology reentry programs employ to reform, remake, and reintegrate formerly incarcerated people, the treatment group (Miller, 2014; Miller, Patton, & Williams, 2015). We turn our attention to the kinds of programs these human service agencies offer, highlighting their strengths and limitations. We ask whether a healthy dose of group work can address social problems associated with carceral expansion. We argue it cannot. Although we find that group work alone cannot overcome the mark of a criminal record, which we suggest is ostensibly a problem of citizenship, we make suggestions on how to leverage the strengths of the treatment group to better serve the needs of formerly incarcerated people. Thus this brief chapter is not a "how to" on criminal justice groups as much as it is an assessment of the state of the field and what one may do to better serve the needs of people with criminal records.

THE RISE OF REENTRY

The 2008 passage of the Second Chance Act reinvigorated political discourse on the plight of the urban poor and the role of public-private collaboration in the design and implementation of interventions to reduce crime. Invoking "the healing touch" of America's "Armies of Compassion," the \$165 million legislation was lauded for living up to its name, helping to ensure that "where the prisoner's spirit is willing, the community's resources [will be] available" (The White House, 2008). Key elements of the legislation included the expansion of job training and work force development initiatives (soft skills) for formerly incarcerated people, increased funding for mentoring programs for the recently released (life skills), increased support for transitional and supportive housing services (case management), and increased funding for court supervision (surveillance; HR 1593). Absent from the act were incentives for employers to hire ex-offenders, restored access for prisoners to Pell Grants for higher education, or opportunities for formerly incarcerated people to expunge or seal their criminal records (Miller, 2014). As sociologist Loïc Wacquant notes, the meager provisions of the act amounted to little more than 30 dollars per month per prisoner (Wacquant, 2010). The target population, largely black and Latino men from low-income communities rocked by deindustrialization, welfare retrenchment, and exclusion from the labor market, coupled with the shape of recidivism interventions embraced by the legislative branch of the federal government with their emphasis on personal development, self-sufficiency, and character building, speaks to the spirit of the Second Chance Act as a highly individualized, character-shaping intervention for the management of poverty in contemporary urban life (Miller, 2013, 2014).

On this note, Miller (2014) posits that prisoner rehabilitation, which was once the hallmark of corrections and based largely on educational programs, vocational training, and employment, has been unseated in favor of psychoeducational group-based interventions that rely on the increasingly fragmented nonprofit social service sector of the postindustrial city to attenuate cycles of arrest, addiction, recidivism, and generational, spatially concentrated urban poverty. Although there has been a notable resurgence of rehabilitative rhetoric in recent years and commitments from policy makers, program planners, and practitioners to offer rehabilitative programs (see Green, 2013), this work largely takes place outside the

prisons' walls in the therapeutic spaces, church basements, and community centers that demarcate the landscape of the low-income, racially segregated, "receiving communities" where most inmates are apprehended and, subsequently, returned upon release (Miller, 2014; Miller, Patton, & Williams, 2015).

This follows long-standing trends in crime control policy. Criminal justice interventions of all kinds are concentrated within poor inner-city neighborhoods (Sampson & Loeffler, 2010; Wacquant, 2009, 2010), where joblessness, low education levels, and residents carrying the stigma of jail or prison records are already in abundance (Street, 2003; Visser & Travis, 2003). This includes the universe of human service agencies designed to address the complex and varied needs of formerly incarcerated people, known colloquially as prisoner reentry organizations (Miller, 2014). With the number of people cycling between a correctional facility of some sort and their disadvantaged home communities, their high recidivism rates, health disparities, cost to the general population, and near intractable poverty, unemployment, and housing instability, prisoner reentry has become a national policy priority (Travis, 2009). But how do these organizations function? What are their goals for program participants? What are the strengths and limitations of this approach?

ON RACE AND RESPONSIBILITY

Prisoner reentry programs attempt to address the cycle of incarceration, release, and repeated rearrest through the provision of social services targeting former prisoners' decision-making processes, their perceived criminogenic needs (e.g., housing, substance abuse treatment, employment readiness training), their criminal thinking, and their perceived anti-social behaviors (Petersilia, 2004; Visser & Travis, 2003). Based loosely on the idea that the actions and behaviors of formerly incarcerated people lead them into a world of crime and criminal activity, reentry organizations employ psychoeducational groups to help them desist from crime. Crime and incarceration, however, are not so neatly linked.

Numerous studies have shown that increased rates of incarceration have not resulted in proportionate decreases in crime (Roeder, Eisen, & Bowling, 2015). That is, an increase in incarceration does not necessarily yield a decrease in crime in a given area. In fact, in some cases the opposite is true (Mauer & Ghandnoosh, 2014). That is, states that lowered their incarceration rates had more dramatic reductions in crime than states that did not (Mauer & Ghandnoosh, 2014). Although jarring, no figures speak more powerfully to the tenuous relationship between crime and incarceration than the current rate of exonerations in the United States. Since 1989, 1,761 people have been found not guilty of a crime for which they were convicted, having served, on average, 9 years in prison (National Registry of Exonerations, 2016). Applying survival analysis to wrongful convictions data, legal scholar Samuel Gross and colleagues conservatively estimate 4.1% of the prisoners sentenced to death are not guilty (Gross, O'Brien, Hu, & Kennedy, 2014). Recent reports from the Innocence Project show that there have been 20 exonerations of inmates on death row, with DNA evidence clearing 263 people of the crimes for which they were accused since 2000 (Innocence Project, 2015). These data alone raise considerable doubt about the presumption of legal guilt one might have of current or released prisoners, or the extent to which people's actions are in some way linked with their arrests. Examining racial disparities in criminal justice outcomes raises even more questions about the relationship between crime and incarceration and, subsequently, the validity of intervention strategies that target former prisoners' perceived behaviors and supposed criminal mindsets.

Overall, black Americans are arrested at twice the rate of their white counterparts and are nearly six times as likely to serve time in jail or prison (Bonczar, 2003). When arrested, black Americans have been shown to do more time. For example, legal scholars Sonja Starr and M. Marit Rehavi find that not only did black Americans receive sentences nearly 10 percent longer than those of whites (Rehavi & Starr, 2012) but also that black men were twice as likely to be charged with an offense requiring a mandatory minimum sentence than were white men with characteristics that were “otherwise similar” (Starr & Rehavi, 2013, p. 29). Upon comparing the arrest rates of black and white American youth, Brame, Bushway, Paternoster, and Turner (2014) estimate that 49% of all black males will be arrested for a nontraffic violation by their 23rd birthdays compared with 38% of whites. Bonczar (2003) shows that while 1 in 18 working-age black women will be incarcerated at some point in their lifetimes, 1 in 111 working-age white women will be incarcerated. In 2007, Latinos represented 40% of all people sentenced in federal court (Lopez & Light, 2009). An examination of police practices supports these trends, offering one partial explanation for the vast racial disparities we see in incarceration and sentencing.

Blacks and Latinos are stopped, frisked, and arrested at much higher rates than whites, although they are less likely to have drugs or weapons or to have actually broken a law when searched (“Racial discrimination in stop and frisk,” 2013). On this point, Goel, Rao, and Shroff (2016) examined the stops made by officers in New York City when the police officers’ stated rationale for the stop was the presumption that the suspect had a weapon. Drawing on police reports to analyze the evidence available to the officer at the time of the stop (i.e., the location of the stop, the race of the suspect, crimes actually reported in the area, the suspect’s description, the time and date of the crime, whether or not the suspect was associated with known criminally involved others, and whether or not the suspect had a suspicious object), the authors estimated the likelihood that the officer had reasonable suspicion to stop the suspect. They found, based on the evidence, that in 44% of all stops, there was less than a 1% chance that the suspect had a weapon and that blacks and Latinos were disproportionately represented among these “low-hit” stops. Examining self-reports of drivers stopped by police, Lundman and Kaufman (2003) find that blacks and Latinos were not only disproportionately stopped but were also less likely than whites to view these stops as legitimate or to report that the officers who stopped them acted properly. Finally, Gelman, Fagan, and Kiss (2007) analyzed data from 125,000 pedestrian stops across districts in New York City by the New York Police Department. They found that blacks and Latinos were more likely to be stopped by police than whites, even when controlling for racial differences in crime participation in the areas in which they were stopped. These findings suggest that disparities in street-level criminal justice contact remain even when controlling for evidence of suspicious activity, the guilt of the presumed offender, the description of the perpetrator by a presumed crime victim, or the recent history of crimes committed in the area by members of the suspect’s presumed racial group. In short, evidence matters very little when it comes to a police stop. Yet the race of the suspect matters quite a bit.

The implicit-bias literature confirms these findings. In studies using video games to simulate police encounters, both the police officers and civilians who were sampled were more likely to shoot unarmed black males than their white counterparts (Correll et al., 2007). In some studies, civilians were more likely to shoot unarmed black suspects than were police officers, and the mistaken police shootings were reduced with time and greater exposure to the simulation (Correll et al., 2007). This offers some hope that recent efforts to reduce implicit bias in police practices may help address racial disparities in arrests and police shootings over time. However, this trend is troubling, as it points to the larger problem of

implicit bias and, subsequently, to the history of racism and racist practices in the United States. When these studies were replicated using multiethnic suspects, including black suspects, both police officers and a comparison group of college-age participants were quicker to shoot armed black American targets than white, Latino, or Asian suspects, but they also showed racial bias in response times and the accuracy of shooting Latinos when compared with Asians and whites and were more likely to shoot whites when compared with Asians (Saddler, Correll, Park, & Judd, 2012).

Racial biases do not exist simply within the community of criminal justice actors but are widely held among the general population. For example, findings from opinion polls consistently reveal that black Americans in particular, and people of color in general, are viewed as older and less innocent (Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2015), less deserving of supportive services (Gilens, 1999; Neubeck & Cazenave, 2001), and more dangerous (Sadler et al., 2012) than their white counterparts. Insidiously, these perceived relationships, which extend to children (Goff et al., 2015), have deep historic roots (Bernstein, 2011). That these biases would be reflected in policing practices are unsurprising. Given such attitudes, it follows that black and Latino Americans together represent 30% of the general population but a full 60% of the nation's inmates (Carson & Sobel, 2014). Audit studies show that employers were more likely to hire whites with criminal records than black Americans who had no prior convictions (Pager, 2008) and that white high school dropouts who had been to jail or prison were only slightly less likely to be called back for job interviews than black Americans who graduated high school and did not have criminal records (Pager, 2008). Even wealthy black Americans were more likely to be incarcerated than poor whites (Zaw, Hamilton, & Darity, 2016), and black Americans with criminal convictions have the worst labor market outcomes of any racial group when surveyed (Pager, 2007).

A MATTER OF CITIZENSHIP

Examining findings on racial disparities in criminal justice contact, processes, and outcomes alone may lead one to conclude that the criminal justice system is an instrument of racial domination. This assumption may not be far from the truth. That is, the oppression of racial groups has been and continues to be largely accomplished through legal means. Thus it follows that if the criminal justice system were an instrument of racial domination, its fallout would be impossible to address through psychoeducation groups. It may be the case that our overreliance on this service technology to address the needs of formerly incarcerated people (Miller, 2014) explains at least some of the high rates of recidivism we see. Or, at the very least, our use of these groups, despite their limitations, speaks to the stubborn disparities we see in the health and well-being of formerly incarcerated people. Disproportionate incarceration would be viewed as the result of a racialized system of domination, and not simply a way of thinking and acting that leads the racialized targets of the criminal justice system into criminal careers. Whatever function we assign it, mass incarceration is a social problem. By definition, it is structural. It may have psychological fallout appropriate for group-work interventions, but the root problem of overincarceration in the United States has less to do with one's engagement in criminal activity than in the criminalization of activities associated with race and poverty (walking while black, driving while black, etc.). The so-called crack cocaine sentencing disparity and research on the outcomes of the war on drugs makes this point clearly.

Conviction for possession of crack cocaine, the presumed drug of choice for many poor black Americans, carried with it a prison sentence that was 100 times greater than conviction for possession of powder cocaine, the presumed drug of choice for many middle-class whites (Families Against Mandatory Minimums, n.d.). Arrests during the “War on Drugs” disproportionately affected poor black Americans and has been called the driver of mass incarceration by scholars and public policy analysts (Alexander, 2012). However, while race, class, drug use, and gender articulate with criminal justice expansion, the rise of the carceral state is not simply a project of racial domination, the drug war, or an endeavor to control poor black men (Gottschalk, 2016). Were every black prisoner to be released today, the United States would still have the world’s largest prison system (Gottschalk, 2016). The same is true for low-level drug offenders, as most inmates in U.S. jails and prisons are convicted of violent offenses (Carson & Sobel, 2014).

The outcomes for formerly incarcerated people have more to do with processes of legal exclusion, policing practices, and discriminatory practices than do their behaviors, choices, and decision making (Miller et al., 2015; Miller & Alexander, 2016). Employers, landlords, and government officials who grant licenses are not only legally able to constrain the social, civic, and political participation of people with criminal records, but changes in liability laws encourage them to engage in practices of legal exclusion (Miller & Alexander, 2016). These changes in liability law, employment, and housing and our understandings of risk and responsibility mean that to be a good landlord, employer, or bureaucrat, one is expected to prevent formerly incarcerated people from working at their job sites, renting apartments from them, or receiving a state license (Miller & Alexander, 2016). The person with a criminal record has no legal recourse, making this a matter of civic rights and therefore, ultimately, a matter of citizenship.

Observing these trends, Miller and Alexander (2016) argue that mass incarceration and its community analogue, mass supervision, have produced a novel form of citizenship in the carceral age based on the *presumption* that one has committed a crime. What they describe as “carceral citizenship” is an alternate citizenship track unique to the largely raced and gendered targets of the criminal justice system marked by a criminal record. This is not *just* a racial project, though race is central to how officers of the law, the court, and the general public perceive risk and thus extend access to goods and services. That is, this is not a form of domination based *exclusively* on race. To this end they write:

Carceral citizenship . . . rests on a presumption of action—in this case the presumption that one has broken a law. Therefore, while carceral citizenship interacts with race, and other axes of difference like class and gender in obvious ways, it is not simply one new form of racial domination built in the image of slavery, or a racial project that produces a new racial category. Carceral citizenship is instead a novel *social arrangement* produced by crime control *practices* born in the era of mass incarceration and its community analogue, mass supervision.

. . . the carceral citizen has unique rights, responsibilities, and claims that it is permitted to make on the state . . . experiences social, political, and economic life in ways that are unique to members of their class, and are not typically shared by even the most marginalized people who have traditionally been marked by their race, religion, ethnicity, or gender. Indeed, the carceral citizen is a novel legal and social category that has emerged in the age of mass incarceration. Carceral citizens face constitutionally justified forms of exclusion based solely on the presumption of legal guilt at some point in their lifetimes.

If the problem of carceral expansion is a problem of carceral citizenship, then even the best reentry program and the best treatment regimen will not be able to resolve its fallout, which in part explains the persistence of vast disparities in the health and well-being of formerly incarcerated people, even in the face of an expansion of reentry services and a decline in the overall prison and jail population.

THE LIMITS OF GROUP WORK WITH CRIMINAL JUSTICE-INVOLVED POPULATIONS

Unable to address the structural barriers associated with the mark of a criminal record (Pager, 2008), reentry programs typically employ group work that is cognitive-behaviorally inspired and designed to address participants' perceived propensities to engage in "criminal thinking" and to activate a presumed latent work ethic and sense of responsibility (Miller, 2013, 2014). Such programs seek to increase participants' human capital, preparing them for the worlds of work and prosocial relationships after prison. While these kinds of programs are certainly needed, given the human capital needs of former prisoners they do not address the practices of legal exclusion former prisoners face that constrain their participation in social, economic, and civic life. In an era in which half of all employers surveyed report that they would not consider hiring a formerly incarcerated person (Pager & Quillian, 2005), where arrests have less to do with one's engagement in criminal activity than the practices of policing in a given area, and where practices of legal exclusion preclude people with criminal records from accessing employment, education, occupational licenses, and access to food and housing (Heck, 2014), it is unsurprising that the most rigorous evaluations of reentry programs have mixed results when examining performance measures such as recidivism, employment, and housing (Bloom, 2006).

It is well known among reentry researchers that substance abuse treatment and employment and housing services can reduce inmate recidivism and increase former prisoners' employment outcomes (Petersilia, 2004; Seiter & Kadela, 2003; Visser & Travis, 2003). Most rigorous studies of reentry show that service provision either has modest effects (Bloom, 2006; Cook, Kang, Braga, Ludwig, & O'Brien, 2015) or, when effects were substantial, were not often long-lasting (Visser, Lattimore, Barrick, & Tueller, 2017). Some even showed negative effects of program participation, attributing the negative criminal justice and employment outcomes to the increased surveillance of program participants. For example, the Minnesota Prisoner Reentry Initiative (PRI) compared findings from participants in a subsidized work and case management program to a historical control group who did not receive PRI services (Minnesota Department of Corrections, 2011). Participants were less likely to secure employment, though they reported higher wages; were more likely to recidivate after 1 year; and were more likely to recidivate quickly. The evaluators concluded that PRI participation did not significantly reduce recidivism or increase employment outcomes. This seems true; however, the design compared the treatment group with a control group from 14 months prior. The treatment group completed services in 2007, right before the great recession. The comparison groups were therefore not equivalent, but the inability of former prisoners to acquire gainful employment during a recession was predictable. The reason is that the labor market matters. Very successful programs, however, had one thing in common. Human capital initiatives that bolstered the soft skills of participants were coupled with education and employment placement programs, housing assistance, and longer term periods of case management support (for examples, see Duwe, 2013; Visser et al., 2016).

Human capital investment alone cannot overcome the constraints of a hostile labor and housing market. Participants, staff, administrators, and program planners from the most effective programs understand and acknowledge the inherent limitations of this approach, noting that this approach is unable to address adequately the structural barriers that limit former prisoners' access to affordable housing, employment, and full civic participation. To address these limitations, rather than simply enhance former prisoners' human capital, they implemented interventions designed to foster the development of social capital, defined here as one's connections to resource-rich social groups. The most recent evaluation from one of the most effective reentry models demonstrates the effectiveness of this approach.

THE WAY FORWARD: THE EMMAUS MODEL

A recent evaluation of an organization one of the authors (R. J. M.) in his research calls Emmaus Road, a faith-based residential prisoner reentry program in a large Midwestern city, shows great promise to merge human and social capital interventions. During a 6-month treatment period, residents were provided with their basic material needs: access to food, clothing, and safe and well-maintained shelter, where human capital investment is accomplished through partnerships with local universities and community groups. Through master's-level social work and psychology internships and a doctoral residency for professional psychologists in training, Emmaus is able to provide its residents with weekly group counseling in anger management, parenting classes, and social skills development and weekly one-on-one psychotherapy. Through contracts with local community partners, residents are provided with twice-weekly substance abuse treatment services, regular medical checkups, work readiness training, and life skills courses, which teach residents to balance checkbooks and take care of the activities of daily living they may not be accustomed to. Through these partnerships, Emmaus is able to provide a series of programs to address the human capital development needs of its residents. At the same time, Emmaus employs an innovative service delivery model that draws on the strengths of peer counselors and community partners (resource-rich social groups) to provide spaces for their residents to use their human capital. This occurs in five main ways.

First, community groups composed of members of local faith communities; running, writing, and other creative leisure clubs; and students and faculty from several local universities participate in informational (discussions of current labor market trends, community updates, health education sessions), leisure (chess club meetings, foreign language courses, exercise groups), or professional development (employment seminars, computer coding) activities each week. For example, the men join a local running club that meets at a waterfront location for a morning run, and writing groups work with the men to publish articles, write short stories, and recite poetry at local establishments. This work provides opportunities for Emmaus residents to leave the confines of their neighborhood and interact with people from many walks of life, providing residents a space for them to use the human capital they've acquired through group work, therapy, and their educational endeavors at Emmaus.

Second, staff and administrators vouch for their current residents with local employers in the area. Construction teams and other local entrepreneurs regularly recruit men at Emmaus for "spot jobs," day labor arrangements that allow residents to make money while they are in programming. The men are encouraged to save the money they make for their eventual graduation. These spot jobs often act as a trial run for long-term employment.

Some employers have hired Emmaus residents to work full time after their graduation from the program.

Third, Emmaus uses a peer mentorship model, employing program graduates to act as a bridge between Emmaus residents approaching graduation and employers and landlords. Staff and administrators at Emmaus have acquired a strong local and regional reputation. Peer mentors who work at the facility meet regularly with employers and landlords throughout the city and broker employment and lease agreements on behalf of the men at Emmaus.

Fourth, Emmaus employs a reentry specialist who maintains contact with program graduates, helping them to adjust to life beyond the program. The reentry specialist does home visits and weekly check-ins with the men, ensuring that they are able to adjust to life after graduation. The reentry specialist plays a particularly important role, given that most graduates of reentry programs recidivate within the first 6 months of program completion.

Finally, Emmaus leverages community partnerships to provide vocational training, a high school diploma (rather than a GED course), college credit through an associated degree program for all who are interested through a partnership with a local university, and opportunities to do service projects with youth designated as at risk in the area.

This approach has proven to be successful. A recent quasi-experimental evaluation conducted by an independent research firm found a 62% reduction in recidivism rates among Emmaus residents when compared with formerly incarcerated men who applied for services but were not able to begin programming due to space restraints. The standardized risk assessment instrument used by corrections officials in Emmaus's home state was used to select participants in the treatment and control groups. Treatment-group participants completed programming at Emmaus in 2012, while the control group consisted of residents who applied but could not participate in programming due to space limitations. Survival analysis was used to determine recidivism and employment rates. In addition to significantly lower rates of recidivism, program graduates were four times as likely as members of the comparison group to acquire full-time employment. Among those who did recidivate, program graduates stayed out of prison longer.

Independent of this evaluation, one of the authors (R. J. M.) conducted a 3.5-year ethnographic study of this program. During this time, program participants repeatedly expressed satisfaction with the services they received. I also found that program participants reported a desire to "give back" to other former prisoners by engaging in mentorship relationships and often reported aspirations of opening reentry programs in their home communities. It should be noted that up to 85% of Emmaus program staff members were program graduates during the course of the ethnographic study, and program graduates who were considered successful were referred to additional social service agencies upon their graduation. Many went on to work in other reentry programs. Although these findings raise important questions about the employment trajectories of former prisoners, Emmaus remains among the most well-respected programs, with among the most robust and long-term effects on recidivism and employment among service providers in its city and home state.

CONCLUSIONS AND IMPLICATIONS: BEYOND GROUP WORK

The literature is clear that former prisoners have human capital needs that must be addressed; crime and punishment are not neatly linked; and contextual, more structural factors are at least as important to address when working with this population as their choices,

motivations, decisions, and behaviors. Unfortunately, most reentry services reflect broader deficit-based discourses on the raced and criminalized poor—that is, that they are dangerous, deviant, dependent, and in need of psychological and cognitive intervention rather than structural support. To address problems associated with mass incarceration and its community analogue, mass supervision, the careful group worker must think beyond the psychologies, rationalities, or even traumas experienced by formerly incarcerated people. The criminal record routes the accused into an alternate track of citizenship. As such, issues associated with incarceration are multifaceted.

Understanding the limitations associated with the most popular strategies employed to serve the criminalized poor, the careful interventionist must employ a set of complementary social capital interventions that broker relationships among former prisoners with resource-rich social groups, such as employers, landlords, and educators. At Emmaus Road, service providers did not approach former prisoners' incarceration histories as a deficit but utilized a strengths-based approach, hiring their graduates in frontline and even key administrative positions. This approach was well received among program participants and the larger community of reentry service providers. More importantly, recent evaluations of Emmaus's service model reveals that participants had lower recidivism rates and higher rates of employment stability than those who did not participate in programming. This aligns with long-term effects found in programs that operate in similar ways. This does not and cannot address the larger problems posed by what Miller and Alexander (2016) describe as carceral citizenship, but it goes much farther in that direction, relieving real human suffering in real time in ways that are more holistic than standard approaches to group work with this population.

Reentry programs can be effective in their endeavors to facilitate the full integration of released prisoners into the social, economic, and political landscape of the cities in which they operate. To do so they must understand and acknowledge the inherent limitations of the most popular approaches to reentry, reimagine the needs of program participants, and bridge the gap in service availability, need, and structural constraints through interventions designed to foster both social and human capital development among formerly incarcerated people.

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PART V

GROUP WORK IN ORGANIZATIONAL AND COMMUNITY SETTINGS

INTRODUCTION

As we stated in the introduction to Part II, the early practice models of group work were developed primarily for members who joined groups for their own enhancement. Because of the social philosophy embedded in social work and particularly in group work, these members were often helped to work for changes in systems outside of the group. Approaches to group work that most strongly emphasized this aspect were included under the category of *social goals model*.

Group workers were aware that their understanding of group processes and ways of facilitating groups could and should be applied to groups that were created to accomplish the purposes of organizations and communities, and this was sometimes labeled “macro” practice. The details of the use of groups in this kind of practice were not as developed as for the groups oriented to individual development. In this book, we seek to introduce the reader to the practice of group work in macro settings.

The first two chapters of this section, Chapters 24 and 25, examine some models that are termed *participatory research*. The idea for this kind of model originated several decades ago as a social science research concept, *action research* (Lewin, 1997). This type of research proposed that research should be a partnership between social scientists and the persons who are the focus of the research; that the research should meet both the needs of the affected persons to change aversive aspects of their circumstances and the wishes of social scientists to understand the processes of social change. This kind of activity has special relevance to group workers, who should seek, in partnership with group members, to understand more fully the processes of social change. In fact, throughout the history of action research, the focus has been on groups of people who sought social change. Chapter 24 contributes ideas that can be used in group-based participatory research by members and practitioners to study the processes in which they are both engaged. Chapter 25 presents some of the emerging kinds of group activities

that are oriented to social change and that lend themselves to this kind of research, namely popular education and popular theatre.

Chapter 26 considers the strategies utilized by groups when they are engaged in bringing about social change, primarily in a community organization context. This is usually termed *social action* and is defined in this chapter as “bringing people together to convince, pressure, or coerce external decision makers to meet collective goals either to act in a specified manner or to stop or modify certain activities.”

Chapter 27 focuses on creating teams, groups that are designed to enable people from different professions or with different roles to coordinate their work toward a common end. Teams face special challenges, not the least which are differences in terminology, status, and perspectives that must be resolved if the team is to accomplish its purposes.

Space did not permit us to mandate chapters on all the other types of groups that exist in community and organizational settings. For Chapter 28, we asked the authors to provide a generic discussion of the kinds of knowledge and skills required of a practitioner in order to work with a variety of task groups created in social work settings.

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Assessing and Strengthening Characteristics of Effective Groups in Community-Based Participatory Research Partnerships

AMY J. SCHULZ
BARBARA A. ISRAEL
PAULA LANTZ

In this chapter, we examine the literature on group dynamics and discuss implications for understanding and evaluating those dynamics within community-based participatory research partnerships. We include a discussion of the development and adaptation of an instrument that can be used to evaluate group dynamics within community-based participatory research partnerships. We close with a discussion of the potential, challenges, and areas for further investigation in the evaluation of partnership group dynamics and the use of such assessments to facilitate ongoing partnership enhancement. The authors' experience has been with partnerships that address the implications of social inequalities for public health, and the examples on which we draw reflect that experience. However, the methods and instruments discussed are readily applicable to community-based participatory research partnerships that address a broad range of issues.

The complex and interrelated nature of many social issues has contributed to interest in the potential of community-based partnerships that bring together a wide range of groups and organizations that pool their resources to address jointly identified concerns. For example, the adverse effects of social, economic, and racial/ethnic inequalities in the United States have become more visible and more visibly intertwined as their contributions to a wide range of concerns has been documented, including their implications for childhood development (Walker et al., 2011); academic achievement (Reardon, 2011; Sullivan, Ketende, & Joshi, 2013); adolescent behavior (Elgar, Craig, Boyce, Morgan, & Vella-Zarb, 2009; Garandeau, Lee, & Salmivalli, 2014); infant mortality (Olson, Diekema, Elliott, & Renier, 2010); and multiple health outcomes (Centers for Disease Control and Prevention, 2013;

Pickett & Wilkinson, 2015). Reducing the inequalities themselves, as well as their adverse effects on those with fewer social and economic privileges, is rightfully a high priority for researchers, service providers, funding agencies, and community groups concerned with education, development, social conditions, and physical and mental well-being. Increasingly, many groups are seeking mechanisms for addressing these complex social issues that engage multiple strands of this web of causation (Blas et al., 2008; Bleich, Jarlenski, Bell, & LaVeist, 2013; Krieger, 1994).

Partnerships offer one mechanism for addressing the complex array of factors that contribute to the adverse effects of inequalities, engaging organizations and individuals from multiple sectors (both public and private) and perspectives, including community members and those from myriad types of organizations to address common concerns. For example, local health agencies and other health service providers, housing organizations, community-based organizations, parents, environmental advocacy groups, and academic researchers may pool expertise, resources, and energies to address childhood asthma (Parker et al., 2008). Understanding the dynamics of such partnerships and how those dynamics may affect the partnerships' ability to work effectively toward their goals is a matter of intense interest to funding agencies, as well as those who contribute time, energy, and expertise toward partnership efforts (Butterfoss, 2007; Clark et al., 2010; Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010; Forsyth, 2009; Green & Krueger, 1992; Johnson & Johnson, 2008; Lasker & Committee on Medicine and Public Health, 1997; Sofaer, 2000).

COMMUNITY-BASED PARTICIPATORY RESEARCH PARTNERSHIPS

The term *community-based research* is used in many ways, sometimes interchangeably with other terms, such as *community-informed research*, *community-involved research*, and *community-centered research* or *community-engaged research* (Israel, Schulz, Parker, & Becker, 1998; Korfmacher, Elam, Gray, Haynes, & Hughes, 2014; Ross et al., 2010). We use the term *community-based participatory research* (CBPR) to emphasize the active engagement and influence of community members in all aspects of the research process, including the integration of the knowledge gained with action to improve the well-being of community members (Horowitz, Robinson, & Seifer, 2009; Israel, Eng, Schulz, & Parker, 2013; O'Fallon & Dearry, 2002).

Coalition approaches to intervention and research bring together partners with diverse perspectives and areas of expertise to work toward a common agenda, often within a defined geographic area, for example, a region or city (Butterfoss & Whitt, 2008; Clark, Friedman, & Lachance, 2006; Lasker, Weiss, & Miller, 2001). CBPR partnerships are one form of coalition in which representatives from communities of identity, professional researchers, and service providers work together to analyze and take action to address prioritized concerns (Israel, Eng, et al., 2013; Johnson et al., 2009).¹ Communities of identity may coincide with geographically defined areas (e.g., an urban neighborhood) or may transcend physical locations (e.g., the black community). The common thread is that members share an identity or sense of connection or purpose that provides a basis for analysis of collective concerns and generation of potential actions to address those concerns (Bell & Lee, 2011; Minkler et al., 2008; Stuart, 1975; Themba-Nixon, 2010).

Participatory approaches to research engage the partners involved both in the development of knowledge and in efforts to address mutually identified concerns. Thus, within

CBPR partnerships, representatives from communities of identity are actively engaged in and influence all aspects of the research process, and professionals (including researchers) are part of the problem solving, as well as the action components, of the effort (Israel, Eng, et al., 2013; Lasker & Guidry, 2009; Minkler, Rubin, & Wallerstein, 2012; Petersen, Minkler, Vasquez, & Baden, 2006). Such partnerships share a number of fundamental assumptions, including the assumption that diverse partners contribute different perspectives, expertise, and resources in identifying and understanding community concerns and the assumption that these multiple perspectives and resources can be engaged to develop solutions to identified concerns (Israel, Eng, et al., 2013). Lasker and colleagues (2001) use the term *synergy*—defined as the ability to “combine the perspectives, resources, and skills of a group of people and organizations” (p. 183)—to describe a group’s ability to work effectively together toward common goals.

In the following sections, we briefly review characteristics of effective groups—which encompass groups that have synergy—as these have been defined by Johnson and Johnson (2012). Next, we describe a conceptual framework that illustrates relationships among these characteristics and the outcomes of CBPR partnerships. Finally, we describe an evaluation instrument and a participatory formative evaluation process that attempt to apply this conceptual framework in a manner that is consistent with principles for conducting CBPR (Israel, Eng, et al., 2013; Israel et al., 1998, 2008; Schulz, Israel, Selig, Bayer, & Griffin, 1998). This evaluation instrument and process can be used by partnerships to assess, discuss, analyze, and take action in addressing concerns related to the group’s working relationships—that is, to facilitate the development of synergy within partnerships. To the extent that such instruments enable partnerships to assess their own group dynamics, they offer one mechanism to evaluate and improve the group dynamics that are essential for successful collaboration. For example, groups that identify ineffective leadership or lack of trust among members may take steps to address these concerns in order to strengthen their ability to reach long-term goals. We close with a discussion of the potential for use of such instruments to promote the development of characteristics of effective groups within CBPR partnerships.

CHARACTERISTICS OF EFFECTIVE CBPR PARTNERSHIPS

CBPR partnerships explicitly seek to bring together groups of people who can combine their perspectives, resources, skills, and ideas to create solutions to community problems. Like any group that comes together with a function or goal, dynamics that unfold among members shape the partnerships’ actions and ultimately their success in working together. The rich literature on group process and group dynamics is useful to those seeking to foster CBPR partnerships. Partnership members, evaluators, and funders are, in the long run, concerned with the outcomes of CBPR partnerships—that is, their ability to achieve specific outcomes and objectives. However, those long-term objectives may become visible only after a period of years. Gaining insights into group dynamics that can contribute to or interfere with a partnership’s ability to create the synergy necessary for achievement of its goals can help partnerships assess their own process as it unfolds. When necessary, such assessment offers opportunities to modify actions or adjust group dynamics to enhance the group’s effectiveness in working together and, ultimately, to further develop its potential to achieve long-term objectives.

Characteristics of Effective Groups

Johnson and Johnson (2012) define an effective group as one “whose members commit themselves to maximizing their own and one another’s success. . . . [Members] believe that their success depends on the efforts of all group members” (p. 20). Based on an extensive review of the group dynamics literature, Johnson and Johnson identify the following characteristics of effective groups: positive interdependence that unites members to achieve clearly defined operational goals; two-way communication; mutual or distributed leadership; decision-making procedures that allow group members to challenge one another’s information and reasoning in a constructive manner; shared power; the ability to resolve conflicts effectively; mechanisms that allow members to hold one another accountable; the ability to appropriately engage the skills and expertise of group members; and the ability to determine how effectively they are working together (see Johnson & Johnson, 2012, p. 20).

Following from the identification of these characteristics, Johnson and Johnson (2012, pp. 24–26) suggest several guidelines for fostering them within groups, which we describe briefly here (see Table 24.1, left-hand column). Guideline 1 recognizes the importance of establishing clear goals for the group that can be defined and measured and that are relevant to the group and its members. These should be goals to which members can commit themselves and that they are unable to achieve by themselves, thus establishing positive interdependence among members. Guideline 2 recognizes that effective group work requires two-way communication that allows all members to participate in the exchange of information, as well as ideas and feelings. Guideline 3 emphasizes the importance of participation and shared leadership, with all members assuming responsibility for being involved in the collective work of the partnership and committed to implementing decisions that are made by the group as a whole. This guideline includes working toward the collective goals of the group, commitment to maintaining working relationships among members, and commitment to the development and growth of the group as a whole. Guideline 4 recognizes the importance of ensuring that power is shared among group members on the basis of expertise, ability, and access to information. Such shared power can promote interdependence and mutual influence among members. Guideline 5 emphasizes the importance of diverse decision-making processes that are consistent with the needs of the situation. Determining the appropriate decision-making process for any given decision involves balancing the time and energy required for various forms of decision making (e.g., consensus vs. top down) against the size of the decision and the commitment of group members necessary to put the decision into practice.

Guidelines 6 and 7 both have to do with the ability of the group to perceive, discuss, and resolve conflicts or controversies effectively. The ability to disagree, challenge, and discuss alternative perspectives on a given issue is fundamental to the ability to identify creative solutions that reflect diverse perspectives and values among group members. Similarly, although partnerships are based on defining shared interests and common goals, conflicts of interest and differences in priorities are inevitable within partnerships. For example, within any CBPR partnership, there are likely to be differences among partners in terms of the relative weight to be placed on research and intervention activities, as well as individual- and community-level intervention efforts. The ability of the partnership to identify strategies to address such conflicts is an important aspect of effective groups. Guideline 8 has to do with the ability of the group to determine how effectively partners are working together. This involves both awareness of group dynamics and opportunities to review and reflect on those dynamics in order to address challenges and strengthen aspects of group dynamics as needed. Such opportunities can be afforded through the use of a formative evaluation process such as the one described here.

TABLE 24.1. Guidelines for Creating Effective Groups and Sample Items for Evaluating Group Dynamics in Community-Based Participatory Research Partnerships

Guidelines for creating effective groups ^a	Sample items from survey instruments for evaluating group dynamics characteristics and intermediate measures of partnership effectiveness within community-based participatory research partnerships ^b
<i>Guideline 1:</i> Establish clear, operational, relevant group goals that create positive interdependence and evoke a high level of commitment from every member.	How much do you feel a part of [partnership or group name]/How much do you feel like you belong to [group name]? How much do you have a sense of ownership over what [group name] does? How frequently do you think of severing your affiliation with [group name]?
<i>Guideline 2:</i> Establish effective, two-way communication within which group members communicate their ideas and feelings accurately and clearly.	How much do people in [group name] feel comfortable expressing their point of view? How much is your opinion listened to in [group name] meetings? How much are you willing to listen to others' points of view?
<i>Guideline 3:</i> Ensure that leadership and participation are distributed among all group members.	How often do you suggest new ideas? How often do you point out ways to proceed when the group is stuck? How often do you invite other members to work with you on specific issues? How often do you place items on the agenda for discussion? To what extent are roles and tasks shared by members?
<i>Guideline 4:</i> Ensure that the use of power is distributed among group members and patterns of influence vary according to the needs of the group as members strive to achieve their mutual goals.	Is your opinion listened to and considered by other group members? Does one person or group dominate the meetings? Do certain individuals have more influence over the decision-making process than others?
<i>Guideline 5:</i> Match decision-making procedures with the needs of the situation.	How true is it that it takes too much time to reach decisions? How true is it that everyone in [group name] has a voice in the decisions? How true is it that good decisions are made? How satisfied are you with the way the decision-making process is working? How much is [group name] able to make the necessary decisions to keep the project moving forward?
<i>Guideline 6:</i> Engage in controversy by disagreeing and challenging each other's conclusions and reasoning, promoting creative decision making and problem solving.	How much do you feel pressured to go along with decisions of the group even though you might not agree? How much do [group name] members listen to each other's points of view, even if they might disagree?

(continued)

TABLE 24.1. *(continued)*

Guidelines for creating effective groups ^a	Sample items from survey instruments for evaluating group dynamics characteristics and intermediate measures of partnership effectiveness within community-based participatory research partnerships ^b
<i>Guideline 7:</i> Face conflicts and resolve them in a constructive way.	In your opinion, what (if any) have been the major points of conflict or disagreement within [group name]? How well do you feel that these conflicts were handled by [group name]? Is [group name] able to resolve conflicts effectively when they arise ?
<i>Guideline 8:</i> Determine how effectively the group is working together.	How well do you think [group name] has been able to work together to solve problems? In working together to solve problems, how well has [group name] been able to identify the important issues and generate several possible solutions? How satisfied are you with the way [group name] deals with problems that come up?

^aJohnson and Johnson (2003).

^bCopies of the questionnaires used in projects highlighted in this chapter are available at www.detroiturc.org and www.hep-detroit.org.

Group Dynamics in CBPR Partnerships

Recognizing the important role of group dynamics in the success of CBPR partnerships, many such partnerships have explicit objectives—in addition to their outcome objectives—regarding partnership formation, intragroup dynamics, relationships among group members, and collective action (Israel, Eng, et al., 2013; Israel et al., 1995; Sandoval et al., 2012; Sofaer, 2000). This emphasis acknowledges relationships between a group’s dynamics (process objectives), members’ perceptions of the partnership itself (impact objectives), and improved community health outcomes (outcome objectives). In other words, the ability of a partnership to reach its long-term objectives is explicitly linked to the success of the group in mobilizing its individual and collective resources to reach its goals and to satisfy the needs of group members.

Figure 24.1 illustrates a model of the relationships among these three types of objectives within the context of a conceptual framework for assessing coalitions. Briefly, the model suggests that the ability of a partnership to reach its outcome objectives is shaped by intermediate measures of partnership success, influenced by the partnership’s programs and interventions. These are, in turn, shaped by the group dynamics that are characteristic of the partnership (called “functional” characteristics by Sofaer [2000]), as well as characteristics of the environment. Group dynamics are also shaped by the structural characteristics of the partnership, including the members, and the environmental characteristics. The characteristics of effective groups described herein can be seen in Figure 24.1 in the box headed “Group Dynamics Characteristics of Effective Partnerships.” The “Intermediate Measures of Partnership Effectiveness” include, for example, members’ perceptions of the effectiveness, benefits, and costs of participation in the partnership, the extent of member involvement, and members’ perceptions of the ability of the partnership to achieve future objectives and goals.

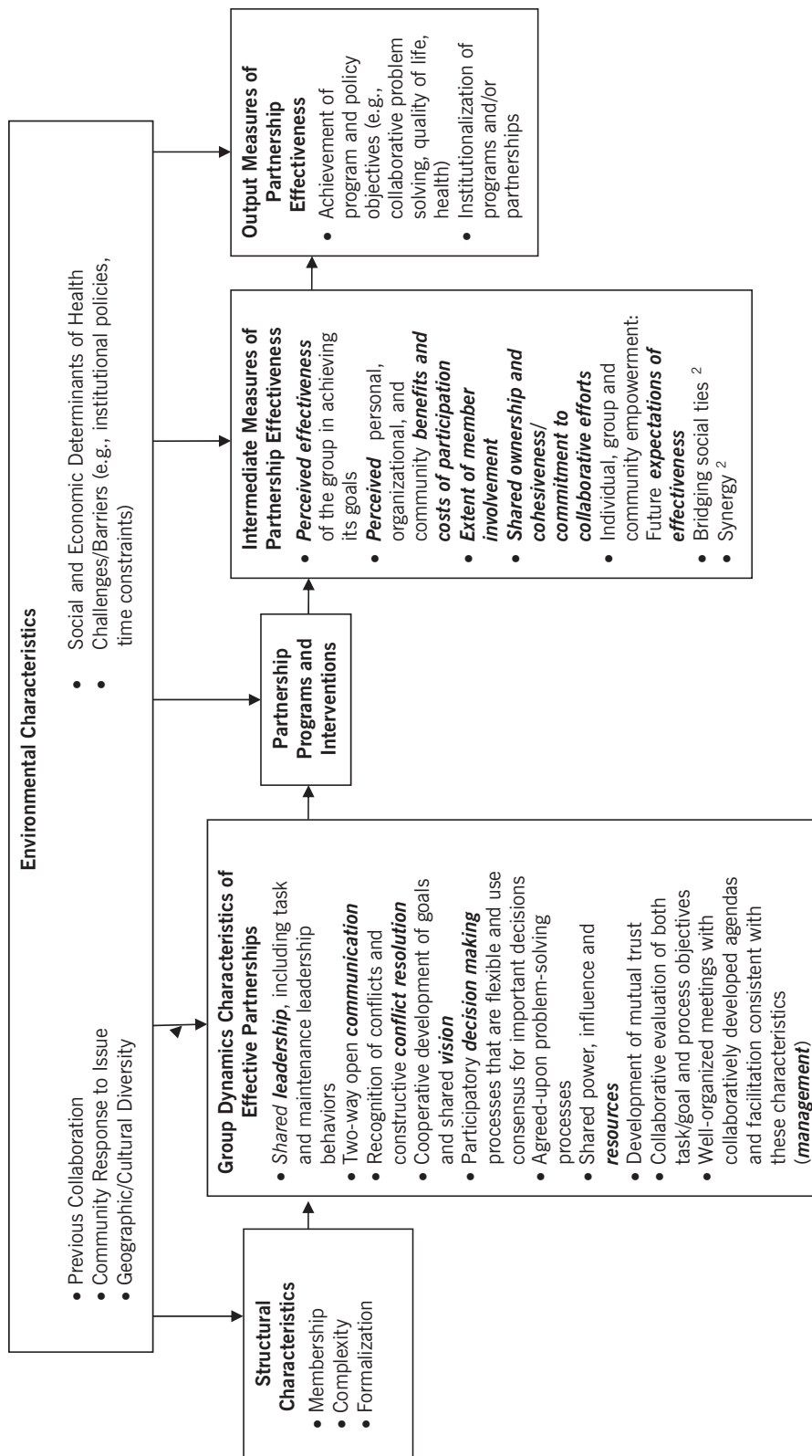


FIGURE 24.1. Conceptual framework for assessing group dynamics as an aspect of the effectiveness of the CBPR partnership process. Based on Schulz et al. (2003), Johnson and Johnson (1982, 1997), Sofaer (2000), and Lasker and Weiss (2003). Adapted from Israel, Lantzi, McGranaghan, Guzman, et al. (2013). Copyright © 2013. Reprinted with permission from John Wiley & Sons, Inc. Italicized and bolded items are derived from Johnson and Johnson (1982, 1997) and are also included in Sofaer (2000). Other items are derived from Johnson and Johnson (1982, 1997).

Prior literature on assessing coalitions or partnerships provides ample evidence supporting the importance of many of these group process characteristics. For example, Butterfoss and colleagues (1996) demonstrated associations between community leadership and shared decision making and member satisfaction and participation in coalitions. Similarly, Lasker and colleagues (2001), based on a review of the literature on community partnerships, described leadership (Lasker & Committee on Medicine and Public Health, 1997), administration and management (Chaskin & Garg, 1997; Israel et al., 1998; Lasker & Committee on Medicine and Public Health, 1997), trust (Baquet, Bromwell, Hall, & Frego, 2013; Goodman et al., 1998; Himmelman, 1996; Kreuter, Young, & Lezin, 1998), and conflict and power differentials (Forrest, 1992; Israel et al., 1998; Kegler, Steckler, McLeroy, & Malek, 1998) as critical aspects of the ability of a coalition to develop synergy. Partners' perceptions of the relative benefits and drawbacks of participation (Brakefield-Caldwell, Reyes, Rowe, Weinert, & Israel, 2015), an intermediate outcome, have been linked to partnership dynamics and are key to understanding partners' level of commitment to and willingness to invest resources in the work of the coalition (Butterfoss et al., 1996; King et al., 2009; Lasker et al., 2001; Torrence et al., 2011; Wallerstein et al., 2008; Wandersman, Florin, Friedmann, & Meier, 1987).

Partnership dynamics and effectiveness in working together has been linked with community capacity building in several studies of coalitions (Anderson-Lewis et al., 2012; Clark et al., 2014; Kegler & Swan, 2012). Partnership synergy has also been linked to the important issue of sustainability of community-based coalitions (Basu Roy et al., 2014; Brush, Baiardi, & Lapidés, 2011).

DEVELOPMENT, ADAPTATION, AND APPLICATION OF AN EVALUATION INSTRUMENT TO ASSESS GROUP DYNAMICS IN CBPR PARTNERSHIPS

The important role played by group dynamics characteristics in the success of CBPR efforts suggests that they are necessary, although by no means sufficient, conditions for the success of the partnership. As the number of partnerships engaged in research and intervention to promote public health increases, so does the importance of using formative evaluation processes to assess group dynamics and, in turn, of feedback and the use of results to strengthen characteristics of group dynamics associated with effectiveness in reaching partnership objectives (e.g., reducing health inequities; Israel, Lantz, McGranaghan, Guzman, et al., 2013). Metrics and processes that enable partnerships to document and evaluate their group dynamics and adherence to key characteristics of effective groups and to address challenges in order to strengthen their effectiveness are critical to the development and maintenance of partnerships that enhance health and health equity (Butterfoss, 2009; Israel, Lantz, McGranaghan, Guzman, et al., 2013; King et al., 2009; Plumb, Collins, Cordeiro, & Kavanaugh-Lynch, 2008; Schulz, Israel, & Lantz, 2003; Wallerstein et al., 2008).

We have developed and used a formative evaluation instrument that was designed to assess central characteristics of effective groups, as described previously, in order to assess group dynamics in several participatory research partnerships.² Each of these partnerships has drawn on results from the assessments to examine and develop more effective group processes. In this section we describe briefly the development and adaptation of this instrument in three distinct CBPR partnerships (in two of them at multiple points in time) and its use as a tool for partnership growth and development. In so doing, we focus on this evaluation instrument as a component of a collaborative or participatory evaluation, one that enables

groups to assess their process and progress toward intermediate and outcome objectives and to make modifications and improvements in their practices as necessary (Brooks, 2010; Butterfoss, 2009; Cheadle et al., 2008; Gajda, 2004; Israel, Lantz, McGranaghan, Guzman, et al., 2013; Plumb et al., 2008). The application described here is an example of one strategy that can be used to promote effective group dynamics within the context of CBPR partnerships (Becker, Israel, & Allen, 2013; Israel, Eng, et al., 2013; Johnson & Johnson, 2012).

Development and Adaptation of the Evaluation Instrument

The evaluation instrument described here was initially developed within the context of a partnership for workplace health promotion (Israel, Schurman, & House, 1989) and subsequently adapted for use within several distinct community partnerships (Lantz, Viruell-Fuentes, Israel, Softley, & Guzman, 2001; Schulz et al., 1998, 2005). It has been subsequently adapted for use in multiple partnerships, several of which are long-standing, and have administered the evaluation at numerous points in time. Based on a review of the group process literature at the time the instrument was initially developed (Blumberg, Hare, Kent, & Davies, 1983; Bradford, 1978; Johnson & Johnson, 1982; Shaw, 1981) and a synthesis of the characteristics of effective groups described herein, specific aspects of group process were prioritized for assessment. The evaluation instrument includes items corresponding to each central group process characteristic (e.g., leadership, participation, communication). Some of these indicators were drawn from existing questionnaires (Alexander, 1985; Burns & Gragg, 1981; Johnson & Johnson, 1982; Seashore, Lawler, Mirvis, & Cammann, 1983), and others were developed to operationalize dimensions for which existing measures were unavailable. The intent was to include items that would enable partnership members to evaluate themselves in light of characteristics of effective groups. Table 24.1, right-hand column, shows sample items from these evaluation instruments and their correspondence to Johnson and Johnson's (2003, 2012) guidelines for creating effective groups.

Because each of the partnerships had different priorities and dynamics, the specific items or sets of items included in the evaluations differed slightly across partnerships, as well as within partnerships over time. Each partnership undertook a process to define the group dynamics characteristics that were most important or salient to them (Israel et al., 2001; Schulz, 1998; Schulz et al., 1998), and those characteristics were incorporated in the evaluation instrument. For example, in one of the partnerships, the distribution of power was particularly salient. Although each of the evaluation instruments included items designed to assess the distribution of power, the instrument was adapted for this partnership to include a more comprehensive set of items on various forms of influence (e.g., decision-making power, community empowerment, equitable distribution of resources) to ensure that the evaluation adequately addressed the priorities of the members. Furthermore, within each partnership, the evaluation instrument described here was one of several methods of data collection (others included, for example, in-depth interviews conducted with partners or field notes collected at group meetings). Within each of the cases examined here, the instrument was revised and adapted over time to reflect concerns and priorities that were identified through these other, open-ended evaluation methods. For example, within the context of two long-standing partnerships, the closed-ended questionnaire has been administered multiple times over 15 and 20 years, respectively, adapting to the changing contexts, priorities, and evolving relationships among members (see Israel, Lantz, & McGranaghan, 2013, www.detroiturc.org, and www.hepdetroit.org for examples of these questionnaires).

Application of the Evaluation Instrument

Just as the evaluation instrument differed slightly across and within partnerships over time, so did the processes used to administer the instrument and feed back the results (see Israel, Lantz, McGranaghan, Guzman, et al., 2013; Lantz et al., 2001; Schulz et al., 2003, for more detailed discussions of these processes). In one case, the instrument was administered during a regular meeting of hourly and salaried employees of an automobile components manufacturing plant who participated in the project (Israel et al., 1989). In the other cases considered here, the instrument was mailed and, in later waves, administered electronically to representatives from community-based organizations, health and social service providers, and academic institutions that were members of the group (Israel, Lantz, McGranaghan, Guzman, et al., 2013; Lantz et al., 2001). In each case, the researchers/evaluators were responsible for administering the evaluation instrument to members of the partnership and for compiling and feeding back the results from the questionnaires to the partnership.

Results were presented back to group members showing numbers and percentages for each question, along with a listing of the number of persons who made up the percentages presented (e.g., 50% = 10 persons). Where relevant, results were also included for previous administrations of the questionnaire, allowing for comparison over time. Within each of the partnerships (one workplace and three community-based partnerships), results were presented at a formal partnership meeting with time dedicated to discussion of the findings, for example, agreement, disagreements, surprises, and interpretations. Partnership members identified a subset of items for more in-depth discussion with discussions often held over multiple meetings—for example, with 15–30 minutes dedicated to this process at each meeting. This opportunity for formative, critical reflection on their process allowed partnership members to identify areas in which they might want to make changes in the way they worked together. For example, in one of the partnerships, first-year survey results indicated that approximately one-fourth of the partnership members felt “somewhat” pressured to go along with decisions of the group even though they might not agree. This finding resulted in a discussion about the group’s earlier decision to use consensus decision making, and partners agreed that they needed to continue to discuss and revise decisions until they reached consensus (Israel et al., 1989). In another example in this same partnership, about one-third of committee members indicated that they felt that it was “somewhat true” that decisions that the partnership made did not get implemented. Based on this finding, the partnership discussed the lack of ongoing involvement of and support from top management in the organizations involved in the partnership and adopted strategies to try to more effectively engage those decision makers as a means to facilitate implementation of decisions made by the group.

Results administered in another long-standing partnership suggested that partners felt that the group’s decision-making process had been key to its ability to accomplish its objectives over time. This group also uses a modified consensus process to guide decision making, encouraging discussion and consideration of alternative perspectives until members are all able to support a given decision (see Israel, Lantz, McGranaghan, Guzman, et al., 2013) for further discussion of this process). Speaking to this issue, a partnership member indicated that “Folks who do not agree with the consensus have their points considered and responded to, and the discussion moves along in a healthy manner without any grudges that I am aware of that may follow into other issues” (Israel et al., 2007). In this same wave of the evaluation, partnership members identified some limitations in the extent to which the current partners adequately reflected the communities in which the partnership was

involved. This led to a series of subsequent conversations, ultimately resulting in decisions to extend invitations to several additional groups to join the partnership, as well as other efforts to engage a broader set of individuals and groups in specific conversations through, for example, planning groups, town hall meetings, and other community forums (Schulz et al., 2011).

In a final example of the use of partnership results to examine and implement changes in group process dynamics, results from one partnership suggested that larger organizations had more consistent participation over time than smaller, community-based organizations, who often had less consistent participation and more frequent changes in representatives (e.g., due to staff turnover). In addition, the survey found that newer members of the partnership reported less ownership over team decisions; were less likely to suggest new ideas, express opinions, or point out ways to proceed when the team was stuck; were less likely to take leadership roles within the team; and were less satisfied with the amount of influence they had over decisions made by the partnership. The group discussed their concern that these findings suggested the possibility that high turnover and less frequent attendance by representatives from smaller organizations with fewer resources could exacerbate differences in influence and leadership between the larger and smaller organizations active in the partnership. The group discussed and implemented several strategies intended to support participation from smaller organizations in an effort to equalize influence and decision-making power between the involved groups. One partnership member noted that as a result of these dialogues: “We became able to put the cards on the table. ‘Let’s do some brainstorming. Let’s do some green-light thinking.’ There are some tough questions that you can’t resolve unless you have some really tough dialogues” (Schulz, 1998).

The different partnerships used a variety of techniques to identify specific issues to be raised for discussion based on the survey findings. In one partnership, an evaluation subcommittee worked with the staff evaluator to determine which issues should be brought to the full group for discussion (Lantz et al., 2001), whereas in the other partnerships, the evaluator presented results to the entire group, and the full partnership prioritized items for discussion (Israel, Lantz, McGranaghan, Guzman, et al., 2013; Israel et al., 1989; Schulz et al., 2003). Criteria used by these partnerships to select items for discussion included issues raised repeatedly over two or more administrations of the survey, items that showed substantial change from one year to the next, or issues or concerns that influenced the ability of partners to participate and have influence in the decision-making process. As an example, when the results of the first survey in one partnership indicated that community partners were disproportionately unsure of how to place an item on the agenda and thus were not satisfied with the degree of influence they had over what was discussed at partnership meetings, these results were prioritized for discussion among the partners. A frank discussion ensued about the meeting agenda-setting process and the importance of the ability of all members (not just a select few) to help craft meeting agendas. The group agreed on a process for getting items on the agenda that was better understood and more inclusive. Following implementation of this process, subsequent evaluation results have shown increased satisfaction with what is addressed at meetings and how meeting agendas are developed.

In each of the partnerships considered in this chapter, presentation of results from the group-process evaluation regularly generated considerable discussion. The presentations have provided opportunities to discuss and refine both the process and the structure of the group, and partnership members have identified these discussions and the ensuing changes as key factors supporting the groups’ achievements (Israel, Lantz, McGranaghan, Guzman,

et al., 2013; Lantz et al., 2001). One partnership member noted: “The trust and relationships we’ve built have really launched the (partnership) and helped out with all of our accomplishments. What really helped was the trust and relationship building that was done” (Lantz et al., 2001). Bringing aggregate data from the evaluation of the group processes to the group provided opportunities for discussion and trust building among partners, as well as for the development of solutions to problems and challenges identified through the evaluation.

DISCUSSION AND LESSONS LEARNED

In each of the projects described above, the group dynamics evaluation instrument provided a structure for discussion of members’ perceptions, concerns, and interactions within the partnership. Systematic data collection and feedback allowed regular identification and discussion of issues and concerns that would have been difficult to raise in the context of ongoing meetings, when task or content objectives were of primary concern. Based on these experiences, we discuss a number of principles and processes that may be useful for facilitating and evaluating the development of characteristics associated with effective groups within CBPR partnerships. Given the critical role that evaluation can play in assessing and enhancing group dynamics, emphasis is placed here on suggested strategies for those involved in evaluation.

Equitable Engagement

Equitable engagement of all partnership members in all phases of the research/evaluation process does not necessarily mean that all partners engage in all aspects of the evaluation to an equal extent. A basic assumption behind a partnership approach is that each partner brings unique perspectives and skills and that the partnership is strengthened through the application of those diverse resources toward a common goal. Thus some members may bring considerable skill and/or interest in evaluation and others may bring in-depth understanding of group dynamics, both of which contribute to building a strong group. It may not be an efficient, or even desirable, use of partnership resources to engage all members in actually administering questionnaires, entering data into a database, or conducting preliminary analyses of the results. All partners, however, have important perspectives and insights to share in interpreting the results of the evaluation and in thinking through ways to address issues and concerns that may be brought to light through the evaluation process.

In some of the partnerships described in this chapter, discussions of evaluation goals and questions were conducted by the full boards and shaped the overall evaluation design (Israel et al., 1989; Schulz, 1998). In others (Lantz et al., 2001), a subcommittee was created to help develop the evaluation, and this subcommittee presented the preliminary evaluation plan to the full board for discussion prior to its finalization. In some instances, the initial plan was developed by the evaluator in consultation with the full partnership and revised later in the group’s development by a subgroup, with input from the full group (Israel et al., 2007). Participatory development of the evaluation plan ensured incorporation of multiple perspectives and group agreement on priorities for evaluation of their process, impact, and outcomes. Once the evaluation plan had been mapped out, those with expertise in data collection and analysis applied their skills, bringing the results back to the larger group for discussion, interpretation, and decisions about action steps.

Furthermore, early in the development of each of the partnerships described here, members engaged in a discussion of the characteristics of groups that they had been members of in the past and that they considered effective or worthwhile groups (Becker et al., 2013; Israel et al., 2001). These discussions generated many of the same dimensions identified in a review of the literature on effective groups or coalitions that achieve synergy—mutual respect, shared leadership, effective governance. They also offered an opportunity for the group to collectively discuss which aspects of group dynamics they particularly valued and, in some cases, generated specific items to be included in the evaluation. Perhaps most important, these discussions provided an opportunity for the group members to “own” the questions included in the process evaluation document and laid the groundwork for later discussions of the results.

Selecting Items for Feedback to the Group

The length of the instruments described here argues against the verbal presentation and discussion of the full set of results. Complete results may be better shared in a written report made available to all members, in combination with presentation and discussion of selected results. The evaluator, evaluation subcommittee, or group as a whole may select particular items or sections for a more focused discussion. This selection may be done in a number of ways.

For example, items or issues that appear to have undergone substantial change between preceding years and the current evaluation efforts could be highlighted. Discussion of change may help to identify precipitating causes and can contribute to the development of constructive suggestions for addressing (or sustaining) those changes. Conversely, in some instances, stability in a set of indicators might be highlighted—for example, issues that surface in multiple waves of data collection or across multiple data collection methods (the group dynamics instrument, field notes, in-depth interviews). Decisions about which issues to highlight can be informed by regular participation of the evaluator in meetings and other partnership events, enabling the evaluator to develop insights into group dynamics, including issues that may arise at particular meetings or carry over as undertones through a series of meetings. Such dynamics may be very difficult to assess through closed-ended data collection strategies alone, which offer only a snapshot at a point in time, or with longitudinal data, repeated snapshots at particular points in time. Field notes and/or open-ended interviews provide important information that contributes to the interpretation of results gathered with a closed-ended instrument and can inform the selection of particular results for feedback and discussion by the group.

Finally, the group may choose to highlight differences in perceptions that occur across subgroups or constituencies within the partnership. For example, with one exception (the worksite health promotion project), the partnerships referred to in this chapter had representatives from a number of community-based organizations, health departments, and academic institutions. Central goals of the partnerships involved the development of equitable working relationships among these types of organizations, each of which brought qualitatively and quantitatively different resources. Therefore, perspectives on the way that the partnership was working together might reasonably be expected to differ—and, indeed, in many cases they did. Such differential results and perceptions provide a basis for conversation and discussion about mutual and reciprocal benefits and identification of actions that might be taken to address imbalances.

Some Considerations and Limitations

There are several limitations to the use of the group dynamics instrument we have described here. First, this instrument focuses solely on group dynamics, that is, relationships among members of the partnership and the ways that they work together. As illustrated in Figure 24.1, there are other important dimensions of any particular partnership that may be considered. Furthermore, data are collected at specified points that may be influenced by recent events that could potentially overshadow longer-term dynamics and trends. The use of closed-ended items on the instruments also may limit their ability to pick up new and emergent issues that are not reflected in the items included. For these reasons, as well as those previously described, we recommend that closed-ended survey instruments to assess group dynamics be used in conjunction with other methods of data collection. Those used by the partnerships described here have included in-depth interviews with partnership members, field notes of meetings, and document reviews (Israel et al., 1989, 2007; Israel, Lantz, McGranaghan, Guzman, et al., 2013; Lantz et al., 2001; Schulz et al., 2003).

The small numbers involved in most partnerships may preclude the use of anything but simple descriptive statistics in data analysis. The fact that most partnership evaluations will consist of censuses (i.e., they are completed by all members, rather than a sample) and the relatively small number of respondents limit the usefulness of tests of statistical significance to assess change over time. Rather, the utility of quantifying this information lies in the ability to give an overall sense of critical group dynamics, especially when combined with other types of data that are collected simultaneously, and to stimulate and shape candid discussions regarding group process and the current state of the partnership among members. Combined with other methods of data collection (e.g., in-depth interviews, participant observation), results can contribute to assessment of group dynamics.

One consideration is whether to track change in individual respondents over time or change in the group as a whole or some combination of these strategies. Simple aggregates of results from two points in time can be useful for obtaining a snapshot of group dynamics but fail to address the question of the extent to which variations over time are due to events that may have unfolded in the group (history), changes in group composition, or some combination (e.g., events that may have affected some group members more than others). Decisions about whether to present results for the group as a whole or for particular subgroups may be based on the particular question being asked, on the extent and nature of turnover in the group between the two points of data collection, or on issues identified through analysis of other data collection efforts (e.g., meeting field notes).

For example, it seems possible that individuals who participate in a partnership over longer periods of time may perceive that they have greater influence in the process and outcomes of the partnership than newer members, potentially a result of skills, relationships, and comfort levels that have developed over time. This effect may be masked in examining aggregate data if, at the same time that some members develop an extended history with the partnership, new members join whose lack of history or experience within the partnership contributes to their feeling that they have little influence. To assess the effects of history and of turnover of members on the overall working relationships among the partners, the evaluator may wish to examine key process indicators by length of membership (and/or intensity of participation) in the partnership. Similarly, there may be differences in experiences and perspectives, for example, between representatives in community-based organizations and those in larger service-providing organizations or academic institutions. Dividing responses

by relevant categories can allow the partnership to examine these differences in some detail and to gain greater clarity on both the processes that drive them and their implications for the group.

Evaluators must, however, take care not to identify or expose individual group members when presenting results, particularly when categories are quite small (e.g., if there are only two representatives from health-care-providing organizations). Potential breaches of confidentiality or anonymity must be guarded against very carefully. In addition to violating basic tenets of research ethics, they also have important implications for working relationships among group members. Furthermore, once respondents have been divided into categories of interest, response summaries will be very sensitive to small changes in membership (e.g., new people), as well as small changes in the assessments offered by individuals (e.g., changing perceptions among long-term members). Group members must take care not to overinterpret changes in light of these sensitivities and at the same time be attentive to the potential implications of such changes.

CONCLUDING COMMENTS AND DIRECTIONS FOR FUTURE RESEARCH

The complexity of many current social issues has led to the development of partnerships that seek to bring together diverse resources, skills, and perspectives to address issues of common concern. A growing body of evidence argues that the ability of such partnerships to realize their potential to work effectively for change rests on the dynamics that emerge among group members. Group dynamics characteristics described in this chapter are consistent with key factors identified in the community coalition literature as associated with the successful formation, implementation, and maintenance of coalitions (Becker et al., 2013; Butterfoss & Kegler, 2009; King et al., 2009; Lantz et al., 2001; Lasker et al., 2001; Plumb et al., 2008; Wallerstein et al., 2008).

Tools that enable partnerships to assess their own group dynamics offer an important mechanism for evaluating and taking action to improve the working relationships that are essential for effective collaboration. As emphasized in this chapter, the use of survey questionnaires of individual partnership members is a core part of such formative evaluation activities. The use of other approaches (i.e., mixed methods) can complement the use of surveys, such as in-depth interviews, or organizational network analysis. For example, a community-academic partnership in Queens, New York, collected longitudinal data to conduct a network density analysis, which revealed positive changes over time in terms of the number and complexity of both informal and formal interorganizational relationships, which in turn were linked to community capacity building and action (Clark et al., 2014). Southerland and colleagues implemented a “give-get grid” as a tool to assess partners’ expectations and perceptions regarding their and other members’ contributions to and benefits derived from the partnership (Southerland, Behringer, & Slawson, 2013). The use of mixed-methods approaches to assess partnership group dynamics and linking these process evaluation findings with impact and outcome objectives is growing (Anderson-Lewis et al., 2012; Collie-Akers, Fawcett, & Schultz, 2013; Doll et al., 2012; Kegler & Swan, 2012).

Despite the limitations and caveats discussed in the preceding section, group dynamics instruments such as the one described in this chapter can be a useful tool for groups whose success relies on the development of effective and equitable working relationships among members. As a formative evaluation tool used in an ongoing manner, such group dynamics

data collection instruments can provide a structured opportunity for group members to engage in discussion and collective problem solving, enhancing the group's ability to meet its goals.

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This chapter was originally adapted with permission from Schulz, Israel, and Lantz (2003). Copyright © 2003 by Elsevier Science. It was updated in 2016 to incorporate findings and examples from subsequent use of the process evaluation instruments described here and new additions to the literature in this area.

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NOTES

1. Again, although our focus here is on CBPR partnerships to address health concerns, similar approaches may be applied to housing, transportation, the environment, or any number of other complex issues. The composition of the partnership and, particularly, the service providers involved may vary accordingly. However, the group dynamics principles and general framework presented here are applicable across a broad range of outcomes.
2. The items are described in Table 24.1.

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CHAPTER 25

Participatory Research, Popular Education, and Popular Theatre

Contributions to Group Work

JANET L. FINN
JILLIAN CAMPANA
MAXINE JACOBSON

In this chapter we examine the relationship of participatory research and popular education, including the tradition of popular theatre, to the theory and practice of group work. We provide brief overviews of the principles and histories of participatory research, popular education, and popular theatre, and we address ways in which they intersect with, are informed by, and potentially inform practice of social work with groups. A number of scholars have addressed the compatibility of popular education and participatory research principles and processes with social work's values and goals of participation, empowerment, and social justice (Alvarez & Gutierrez, 2001; Atkinson, 2005; Barbera, 2008; Branom, 2012; Finn, 1994; Healy, 2001; Hick, 1997; Jacobson & Rugeley, 2007; Poertner, 1994; Sohng, 1992). However, few have systematically examined their fundamental connection to principles and practices group work (Barlow & Hurlock, 2013; Becker, Israel, & Allen, 2005). We explore this connection and show how participatory research, popular education, and popular theatre have been utilized as forms of group work for social justice and community change (Jacobson & Rugeley, 2007). We address the role performance plays in popular education and participatory research and its relationship to group process. By "performance" we mean conscious human interaction in theatre and other social contexts. The literature on social group work offers diverse examples of the use of performance to evoke feeling, provoke dialogue, and promote action (Kaplan, 2001; Halperin, 2001; Malekoff, 2006; Middleman, 1983). However, there has been less attention to the specific group processes through which these significant interactions contribute to consciousness raising (conscientization), capacity building, and change (Houston, Magill, McCollum, & Spratt, 2001). Here we forge

direct links to the concept of *popular theatre*, a form of popular education that employs the performing arts, as a means of critical reflection and catalyst for action (Boal, 1985; Kraai, MacKenzie, & Youngman, 1979).

Drawing from contemporary literature, we show how scholars, activists, and community members are creatively and critically embracing these modes of inquiry and action in collective pursuit of social justice and social change today. We highlight processes and skills of group work utilized in a variety of projects employing participatory research, popular education, and popular theatre strategies. We conclude with reflections on how these approaches contribute to our understanding and practice of group work.

MAPPING THE TERRAIN

Participatory Research

Participatory research can be described as a collaborative approach to research that integrates systematic investigation with education and political action (Maguire, 1987; Minkler & Wallerstein, 2003; Sohng, 1992, 1996).¹ Participatory research calls for the meaningful involvement of people in the coproduction of knowledge to address the concerns that affect their lives. It challenges the separation of researcher and “subject,” and it takes power and inequality as central themes. The research process is conceived as a catalyst for transformative action. In particular, participatory research seeks to enhance participants’ power and control over the conditions that affect their lives, attend to power relations among participants, and develop power-sharing processes of knowledge development and action (Alvarez & Gutierrez, 2001; Barbera, 2008; Israel, Eng, Schulz, & Parker, 2005).

Participatory research is a form of *praxis* involving critical reflection and dialogue, development of critical consciousness, and democratized processes of inquiry among participants (Brown, 1985; Brown & Tandon, 1983; Gaventa, 1988; Lather, 1986; Maguire, 1987). Participatory researchers are not neutral observers but grounded actors engaged in relationship and dialogue with coresearchers and community members (Barbera, 2008). They strive for critical awareness of their own subjectivity in the research process (Finn, 1994; Lather, 1986, 1991; Maguire, 1987; Park, 1993, 1997; Sohng, 1992, 1996). In sum, participatory research is characterized by collaboration, consciousness raising, capacity building, recognition of diverse voices, and commitment to promoting strengths of participants in the pursuit of justice-oriented change (Becker et al., 2005; Branom, 2012; Finn, 1994; Minkler & Wallerstein, 2003).

Popular Education

Popular education has been defined as a strategy for social change in which people struggling under conditions of oppression come together in small groups to critically reflect on the conditions of their lives; to become conscious of the social, political, and economic contradictions in which their social experience is bound; and to utilize the power of the group as a resource for transformative action (Freire, 1970, 1998a; Weiler, 1988). It emerged as a grounded approach to adult literacy education through which people come to know the word through knowing the world (Freire, 1970, p. 13). Through dialogue with others, people connect their personal troubles to broader structural problems in society and strive to rectify these conditions through collective action. The educational process is a cyclical,

iterative one of becoming critically conscious of one's social reality, historical and political positioning, and human agency, which, in turn, shapes one's capacity for action and further critical reflection (Freire, 1970, 1998a, 1998b; Poertner, 1994).

Similar to participatory research, popular education starts from the assumption that education is not neutral and thus consciously attends to questions of power and emphasizes reciprocity between teachers and learners (Chang, 2013). As Cho, Paz y Puente, Louie, and Khokha (2004) describe, popular education builds from the lived experience of participants, creates spaces to nurture trust, encourages active participation, and draws on multiple modes of learning and expression, including theatre, music, visual art, and games, as well as group dialogue. It helps people make connections between lived experiences and broader structures and relations of power, and it promotes individual and collective empowerment as participants develop strategies to transform unjust power arrangements. Finally, popular education encourages the development of community leadership and capacities and affirms the dignity of all participants (Cho et al., 2004).

Popular Theatre

As introduced above, *popular theatre* is a form of popular education that uses performance as a tool for dialogue, conscientization, and transformation. Popular theatre is an educational process that is available to everyone and can be performed anywhere. It covers a wide range of theatrical activities, including drama, dance, puppetry, and song. These theatrical techniques engage people in examination of the issues that affect their lives, facilitate communication and interaction that spark awareness of collective oppression, and encourage development of viable strategies for action (Bates, 1996; Boal, 1985; Srikandath, 1991). The content of popular theatre is created by the participants, not mandated by an outside force (Kraai et al., 1979). The goal of popular theatre is to research and respond via participatory performance to the social, economic, cultural, and political conditions that have shaped people's lives (De Costa, 1992).

Brazilian theatre scholar and practitioner Augusto Boal, a key figure in popular theatre and founder of the international movement Theatre of the Oppressed (TO), created a technique called *Forum Theatre*, which exemplifies these notions. In Forum Theatre, the line between actors and audience is blurred. Both are *spect-actors*, a term Boal coined to mean one who simultaneously observes and acts. The Forum Theatre process generates a scripted play that explores an identifiable, yet unsolved, problem. In keeping with a key aspect of popular theatre, Forum plays explore issues that are not only pertinent to the lives of the participants but that are chosen by the participants. After the play is presented to the audience, it is discussed and presented again. During several subsequent performances any spect-actor who is watching the performance and not yet on stage may stop the action and come on stage to replace a character, namely a protagonist, ally of the protagonist, or neutral character. When audience members are invited on stage to demonstrate their ideas, they are engaged in an empowering process of simultaneously imagining and practicing change.

Unifying Themes

Participatory research, popular education, and popular theatre are not simply methods or techniques but modes of inquiry and action with a common philosophical base and political commitment. They share the epistemological assumptions that knowing is a "permanent human process, not an individual event but a social one, a historical one, a cultural one"

(Freire, 1985, p. 11) and that knowledge of the world is co-created through critical dialogue about lived experience in the world. Participatory research, popular education, and popular theatre see knowledge as power and seek to democratize practices of knowledge production. They challenge hegemonic notions of “power over” and promote alternative forms of power—power within, power with, power to do—among people living in conditions of oppression (Townsend, Zapata, Rowlands, Alberti, & Mercado, 1999). They are transformative processes that recognize ordinary people as protagonists of knowledge development and change. In so doing, they blur the boundaries between researcher and researched, teacher and learner, and actor and audience.

The Role of Group Processes

Participatory research, popular education, and popular theatre are fundamentally *group* processes through which participants problematize their social reality and build collective capacity to challenge and change that reality. They acknowledge the significance of a sense of belonging, connection, and trust among participants; the importance of equitable, open communication; and the ability to actively and respectfully address conflict as key to process and outcome (Becker et al, 2005; Cho et al., 2004). They utilize group processes of listening, question posing, dialogue, assessment, decision making, action, and reflection that engage participants and help create in the group both an awareness and power to act (Carroll & Minkler, 2000; Freire, 1970, 1998a; Poertner, 1994). They recognize that intersecting forms and mechanisms of oppression along particular axes of difference, such as race, class, gender, sexual identity, age, and citizenship, shape collective as well as individual experience. They address the power of oppression to produce isolation and alienation. In response, they emphasize practices of mutual aid, trust building, crafting of group solidarity, and honoring of difference. As Becker and colleagues (2005) describe, the success of these participatory endeavors depends on respectful attention to group dynamics and group processes through which members develop trust, norms, commitments, and leadership.

HISTORICAL PERSPECTIVE

As instruments of social change, participatory research, popular education, and popular theatre developed from conditions of social, economic, and political discontent. A historical perspective is helpful in understanding these approaches, appreciating their political and ethical grounding, and seeing connections to the group work tradition.

Participatory Research

Historians of participatory research attribute the first use of the term to Tanzania in the early 1970s (Hall, 1981). A number of writers have linked the beginnings of the participatory research tradition to work with oppressed peoples in Latin America, Africa, and Asia, often in response to exploitative development projects and policies (Brown & Tandon, 1983; Hall, 1981; Maguire, 1987; Tandon, 1981). Hall (1981) contends, however, that long before participatory research was named, its principles and practices could be traced to early social investigations conducted by Engels (1968) and Marx in the mid-1800s and the contributions of John Dewey, George Herbert Mead, and scholars of the Tavistock Institute in London who challenged positivist approaches to knowledge production.

Social work was also an early forerunner in participatory research methods utilizing group processes in social investigation from the early days of the settlement house movement. Settlement house workers teamed with neighborhood residents to conduct investigations into conditions resulting from the contradictions of industrial capitalism and to advocate for social reform (Addams, 1910). For example, in *Twenty Years at Hull House*, Jane Addams (1910) reflects upon an investigation into deplorable sanitation conditions in the neighborhood conducted by members of the Hull House mothers' club. With the support of Hull House residents, who provided education on the connections between public sanitation and infant mortality, this group of immigrant women came together, shared their concerns for their children's well-being, systematically documented the conditions of neighborhood streets and alleys, and used their findings to advocate policy change (Addams, 1910, p. 284). Ultimately their efforts promoted systematic garbage removal and decreased infant death rates and paved the way for other social investigation. They utilized mutual aid processes of question posing, information sharing, and consciousness raising to inform collective action.

Similarly, research in the social survey movement, which began around the turn of the 20th century and gained momentum through settlement houses, drew on and informed the power of group work (O'Connor, 2001; Zimbalist, 1977). Social surveys were an integral component of community organizing, social work with groups, advocacy, and social reform (Kellogg, 1914; Malekoff, 1994; Wagner, 1991). Thus an interest in systematic investigation of social problems informed by and in partnership with those most affected by those problems dates to the inception of social work in the United States.

Popular Education

Scholars often cite Brazilian educator Paulo Freire as a starting point for discussions of popular education. However, as Noelle Wiggins (2011, p. 357) notes, the term *popular education* was used in early nineteenth-century Latin America to refer to universal elementary education. By the early twentieth century students influenced by Marxist thought set up "popular universities" in a number of Latin American countries to provide basic education and introduce socialism to farmers and workers. Similarly, political leaders such as Augusto Sandino and Lazaro Cardenas promoted critical adult literacy for the poor and working classes in their campaigns for social transformation in Nicaragua and Mexico (Wiggins, 2011). Freire, influenced by this legacy, developed his educational philosophy and practice through his thirty years of literacy work with impoverished people in Brazil. Freire's best-known work, *Pedagogy of the Oppressed* (1970), is a treatise on popular education.

While Freire's work is most well known, forms of popular education have evolved independently and created momentum for social movements around the globe (Hurst, 1995). For example, roots of popular education can be found in the Danish folk school movement. Nikolai Frederik Severin Grundtvig, a theologian and educator, promoted "schools for life" to retain the language and cultural identity of the Danish people in the face of German imperialism in the 1880s. Through the movement, ordinary people collectively developed their capacities to address problems of everyday living (Kohl, 1991).

Danish folk school philosophy influenced the work of Myles Horton, cofounder of the Highlander Folk School in Tennessee, which is committed to popular education as an approach to social transformation (Adams, 1972; Horton, 1998). Horton first used the term *popular education* to describe his early community work in the Cumberland Mountains, where people came together to share stories of their everyday lives (Wiggins, 2011). Horton

later studied in Chicago and sought out mentors such as Reinhold Neibuhr, John Dewey, and Jane Addams, who expanded his thinking about education rooted in the existing knowledge and experience of learners. Horton then traveled to Denmark in 1931, where he studied the Danish folk school movement. It was ultimately through his work at Highlander, where people came together to learn and teach one another, that he became convinced that “education must come from the people and the situations they confront in their everyday lives” (Adams, 1972, p. 42). Popular education continues to be a key strategy for community change grounded in the collective power of oppressed groups (Checkoway, 1995).

Popular Theatre

Popular theatre has long been an instrument of social change. Performance has always been deeply woven into human cultural experience, as evidenced in collective ceremony and ritual (Turner, 1969), and diverse forms of performance have often served as vehicles for promoting empowerment, creating and sustaining community, and enabling artist and audience to express emotion and thought. Popular theatre likely emerged from such community performances, and it continues to be shaped by political and social contexts. Examples include ancient Greek plays, often social commentaries, instigating new social practices and ways of thinking, as well as the *commedia dell'arte* plays that traveled the European countryside in the 16th and 17th centuries presenting stories that commented on the many discrepancies between the lower and upper classes. Recent examples include the Vermont-based Bread and Puppet Theatre started by Peter Schumann in 1969, which aims to unite communities through theatre, and Northern California's El Teatro Campesino, founded in 1965 by Luiz Valdez to support the United Farmworkers Union. El Teatro Campesino's work began with actors performing short skits in flatbed trucks about the plight of farmworkers and today continues to create performances that challenge Chicano and Latino stereotypes and support workers' rights (Jacobs, 2007).

As mentioned previously, Boal's Theatre of the Oppressed (TO) movement is a powerful example of popular theatre. When Boal became the artistic director of the Arena Theatre in São Paulo in the 1960s, he began to take performances into the rural countryside. While working with community members and actors together, he developed the varied techniques that constitute the TO tradition. Named after Freire's *Pedagogy of the Oppressed*, TO incorporates Freire's principles by using the medium of popular theatre as the tool for creating knowledge and initiating transformation among people living in conditions of poverty and oppression (Bates, 1996; Paterson, 2011). Like Freire, Boal was persecuted for the idea that common people could have a say in the issues that affect their lives. (Both men were exiles during Brazil's military dictatorship and took their philosophies to international audiences before returning to live in their home country.) TO techniques ask participants to make connections between their personal plights and structural inequalities and, armed with this knowledge, to create realistic strategies for transformative action (Boal, 1985). Popular theatre techniques have been embraced as part of many people's movements and grassroots change efforts because they present a mode of collective inquiry whose potential has recently begun to be tapped by social workers.

Relationship to Group Work Tradition

Group work was born from the same social, political, and economic conditions of discontent as participatory research, popular education, and popular theatre. Janice Andrews (2001),

quoting Judith Lee (1991, p. 3), states that, "From its beginnings, group work practice and theory has been rooted in social reform, social responsibility, democratic ideals, and social action as well as social relatedness and human attachment." As William Schwartz (2006) describes, the practice of people coming together in small groups for mutual aid was a foundational aspect of nascent social work emerging at the turn of the 20th century in the United States. Buffeted by the pressures and contradictions of industrial capitalism, immigrants and their allies formed groups to provide safe haven amidst this sea change. African Americans migrating to northern urban industrial centers turned to group practices of mutual aid to survive in the face of entrenched racism and social and economic exclusion and to build bases for collective empowerment (Carlton-LaNey & Burwell, 1996; Hounmenou, 2012). Groups helped their members meet immediate needs and also served as venues for education in political power and social participation (Schwartz, 2006).

Group work theorists put forth the radical idea that human nature is fundamentally *social*, challenging the individualized concepts of personhood favored by dominant psychological thought. They further theorized about the dynamic, emergent, and socially constituted nature of personhood (Schwartz, 2006). For example, former settlement house worker and theorist of organizations and group work Mary Parker Follett put forth a concept of "circular behavior," "that emphasized the reverberating character of human exchanges, in which each actor responds to a situation he helped create a moment ago. She pointed out that 'response is always to a relation. I respond not only to you but to a relation between you and me'" (Follett, 1940, cited in Schwartz, 2006, p. 77). This sense of the emergent social self, both shaped by and shaping the group, is at the heart of participatory research, popular education, and popular theatre processes as well.

In sum, participatory research, popular education, and popular theatre share unifying themes with the group work tradition. They recognize people's capacities as interpreters of their social realities. They honor the power of dialogue through which knowledge for social action is created and shared in the context of relationship and collaboration. They promote shared control, shared power, and shared agenda (Schwartz, 2006, p. 85). They acknowledge the need for contexts of support in which people can question their reality and build critical consciousness. They recognize the performative nature of praxis as a process of being, doing, and becoming (Kelly & Sewell, 1988). They see personal and social transformation as mutually constituting processes.

LEARNING FROM CONTEMPORARY PRACTICE

Over the past two decades, social workers have been drawing on the group work tradition as they bring participatory approaches to bear in research and practice. For example, researchers have used participatory modes of inquiry to engage the expertise of people experiencing homelessness, develop critical awareness of structural inequalities, and advocate for program and policy change (Fetherman & Burke, 2015; Yeich, 1996). Scholars have used participatory inquiry to understand and address racial and economic disparities regarding health and access to health care and healthy foods (Ammerman, 2012; Ayala, Maty, Cravey, & Webb, 2005; Gehlert & Coleman, 2010; Jacobson & Rugeley, 2007). Scholars have developed collaborative research partnerships with tribal leaders and members in diverse American Indian communities in efforts both to address significant social and health issues and to redress destructive practices and relations of power that have characterized much of

traditional social science research among indigenous peoples (Caringi, Klika, Zimmerman, Trautman, & van den Pol, 2013; Christopher, 2005; Hartman, Wendt, Saftner, Marcus, & Momper, 2014; Johnston-Goodstar, 2013; Koster, Baccar, & Lemelin, 2012). Participatory research methods have also been embraced by scholars seeking to involve children and youth in examining and acting on the concerns that shape their everyday lives (Fetherman & Burke, 2014; Ozer, Newlan, Douglas, & Hubbard, 2013; Powers & Tiffany, 2006; Torronen & Vornanen, 2014). Participatory projects have engaged people living with mental illness in examination of mental health systems and policies; youth in out-of-home placement in analyses of foster care systems; persons with disabilities in addressing violence in their lives; and survivors of interpersonal violence in program evaluation and advocacy (Case et al., 2014; Faigin & Stein, 2015; Raymaker & McDonald, 2013).

Photovoice

Social work scholars have also begun to incorporate expressive arts into modes of participatory research, as exemplified in Izumi Sakamoto and colleagues' collaborative arts-based research on women experiencing homelessness in Toronto (Sakamoto, Chin, & Baskin, 2010). Of particular note is the growing attention to photovoice as a method of participatory inquiry and action employed in social work research. Photovoice is a participatory approach to research, advocacy, and action that involves participants in representing their social realities through photo taking, critical reflection, and presentation of results (Wang & Burris, 1997). Photography provides people with a means of accessing and depicting their worlds and providing others with windows into their worlds (Wang, Burris, & Xiang, 1996). As participants take cameras into their own hands, they take up the task of visually representing their experiences and concerns and communicating those experiences and concerns to others, with the goal of changing policies and practices. Molloy (2007) asserts that photovoice, as a participatory approach to research and advocacy, has the potential for furthering the social justice mission of social work.

There is a burgeoning literature in social work that utilizes photovoice as a key participatory research strategy to document the experiences and perspectives of diverse groups, from young women experiencing serious illness (Burles & Thomas, 2013) to youth identifying personal and community strengths (Dakin, Noyes, Arnell, & Rogers, 2015) to women engaged in sex work using images to document their agency and resistance (Desyllas, 2014). Recently some scholars have suggested that photovoice be incorporated in the research and pedagogical training of social work students, further suggesting the potential value of this modality that brings collective, participatory knowledge development and expressive arts together in social work research and practice (Mulder & Dull, 2014; Peabody, 2013).

Although those utilizing participatory research approaches often acknowledge the importance of group work in the process, few have systematically examined the dynamics of group work and their significance to the project. The recent work by Constance Anne Barlow and Debb Hurlock (2013) on the group dynamics of a photovoice project with former sex trade workers is an important exception. Barlow and Hurlock examine the group processes through which participants collaborated in creating a space of safety; compared their experiences; engaged in the co-construction of meaning; provided feedback; watched out for one another; made decisions; and negotiated nuanced questions of power, safety, and trust over time. Their important work places group work center stage and shows how and

why attention to group work is critical to the process and outcome of these participatory approaches to knowledge development and action.

Social Work and Popular Theatre

A few social work scholars have embraced popular theatre as a component of participatory research and collective action for change. For example, Stan Houston and colleagues (2001) incorporated Theatre of the Oppressed into a Donegal County, Ireland, community employment project with poor, unemployed adults to uncover their common experiences of oppression, explore barriers to employment, and strengthen their capacities for realization of their social and economic potential (Houston et al., 2001). More recently Izumi Sakamoto and colleagues have used theatre as a component of a participatory research project to explore the employment challenges facing skilled immigrant workers in Canada (Chin, Sakamoto, & Bleuer, 2014; Sakamoto, Chin, & Young, 2010). In prior research on the sociocultural adaptation of skilled immigrants to Canada, Sakamoto and her research team had found that lack of “Canadian experience” was a significant barrier. At the same time, they found “Canadian experience” to be a rather vague concept embedded with tacit assumptions about “soft” as well as “hard” skills that are presumed necessary from an employer’s perspective (Chin et al., 2014, p. 263). The team began to ask critical questions about the meaning of “Canadian experience” and whether it constituted a real issue or served as a euphemism for practices of employment discrimination (www.beyondcanadianexperience.com/home, 2014). They turned to popular theatre, specifically the techniques of *democracy theatre*, as a mode of inquiry to try to tease out the meaning and power of the “Canadian experience” (Chin et al., p. 264). In consultation with a popular theatre specialist, the team used focus groups to engage participants in creating characters to represent a “professional new immigrant” and a “seasoned Canadian professional.” It was in this group context, enlivened by the performative aspects of theatre, that participants were able to more concretely capture the meaning and power of “Canadian experience.” The characters they created provided the basis for critical dialogue about underlying perceptions, dynamics, and tensions embodied in the construct of the “Canadian experience” that served as barriers to employment for skilled immigrants. The team’s research found “Canadian experience” to be a significant barrier for many skilled immigrants, and their investigations have informed human rights advocacy to remove this barrier. (See www.beyondcanadianexperience.com/home for a full account of ongoing advocacy work.)

Wernick, Woodford, and Kulick (2014) document the blending of participatory research and theatre to empower LGBTQQ youth in raising the consciousness of adults about school climate and engaging adults in changing attitudes, actions, and policies. They describe the work of Riot Youth, a community-based LGBTQQ and ally youth organization, and its affiliated Gayrilla Theatre in documenting youth experiences and concerns regarding safety, harassment, isolation, marginalization, and intervention in the school context. The youth researchers conducted surveys and focus group interviews with youth and adults in local schools over a 3-year period. They prepared a formal report of their research findings and opted to deliver their findings not only in report form but also through Gayrilla theatre performances in which examples of the everyday micro-aggressions experienced by LGBTQQ youth were enacted for adult audiences. According to Wernick and colleagues (2014), it was the combined effect of the extensive research data and the presentation through theatre that moved adult audience members to be change agents and allies as evidenced in their

individual awareness and action, acknowledgement of systems failures, and willingness to make concrete changes in school policies and practices.

BLURRING BOUNDARIES AND BRIDGING DISCIPLINES

Social work has much to gain from further engagement with popular theatre as a strategy for participatory knowledge development, consciousness raising, and action for change. There are many examples of such work in theatre and drama literature, which is sometimes referred to as “social theatre” (Schechner & Thompson, 2004), “theatre for development” (Epskamp, 2006), or “applied theatre” (Prendergast & Saxton, 2010; Prentki, 2015). One example is Boal’s Legislative Theatre, which uses Forum techniques to ask for policy changes from various governments (Boal, 1998). Legislative Theatre has provided concrete evidence of the use of popular theatre to change social policy. Here participants research social issues they want addressed and use performance as a means of education and advocacy. The first law approved with the aid of Legislative Theatre maintains that all municipal hospitals in Rio de Janeiro must have doctors on staff who specialize in geriatric health. Until this law went into effect in 1995, virtually no hospital in the city employed specialists in geriatrics. Yet another example of adult educators and community practitioners incorporating popular theatre in their change efforts (Hammond, 1999; Valla, 1994) comes from Boston’s Theatre Offensive group, which runs a program for LGBT young adults and their straight allies (Bent, 2014). True Colors: Out Youth Theatre is a group of lesbian, gay, bisexual, queer, transgender, and questioning youth that uses social work and theatre to both write and perform stories from the participants’ lives. There are many programs such as this around the United States, but here we highlight two international examples to specifically connect the practices of popular education, participatory research, and popular theatre and to illustrate both the potential and challenges for group work and community practice.

Theatre and Rehabilitation: Framnäs Folkhögskolan

Framnäs Folkhögskolan in Pitea, Sweden, is a folk high school following Grundtvig’s model. It provides residential adult education not leading to a degree but, rather, focusing on developing the student as an individual and a productive member of society. Framnäs has several education programs on their campus, including a music program, a computer program, and an audiovisual program. They also offer a program for adults living with severe neurological problems, called Neurolinje. Most of the students in that program are survivors of traumatic or acquired brain injuries who come from all over Sweden and Scandinavia after they have been released from the hospital or rehabilitation center and typically before they return home to seek to reintegrate into their family, personal, professional, and social lives. The staff of the Neurolinje program is composed of social workers who work in many different capacities. Some of the staff teach classes, whereas others work more individually on social and emotional issues. Classes are offered in nature and environment, stress reduction, computer skills, English, and current events, and since 2005 Neurolinje has offered a theatre program that uses drama as a tool in the survivor’s rehabilitation process. In these classes students focus on using their voices and bodies to express their feelings and desires, and they also use role play to explore relationships and to practice behaviors and skills they hope to be able to put to use once they return home (Näslund & Gardelli, 2013). Jillian Campana

worked with Swedish health care and social workers, including the Neurolinje program director Inga Granström, to put the theatre curriculum in place. Having worked with survivors of brain injuries previously, she knew that this population often experiences disassociation from their previous identities (Campana, 2005). Often survivors have deficits that make activities they were able to easily accomplish before the injury difficult; they struggle to understand how other people's perceptions of them have changed; and they sometimes need to embrace a new and different identity. At Framnäs Folkhögskolan, Campana uses popular theatre techniques to facilitate discussion among the students that focuses on issues pertinent to their lives. Often, with the help of Framnäs staff, students email her stories of their struggles and triumphs before she arrives so that she is prepared to focus on topics the students have identified, and she chooses theatre exercises that develop specific skills that might assist the students in dealing with said topics. For example, if the student population identifies vocal restrictions (such as an inability to speak or aphasia) as an issue they would like to address, Campana brings a series of theatre exercises that encourage and privilege physical communication. In this way, the focus and content of the work that is undertaken is driven by the students from the very beginning. Each year the Neurolinje students write and act in short plays that offer the audience (often composed of their care staff) a glimpse into their disabilities from their perspectives and that present themselves and their strengths in a positive way. Participants in these theatre classes have cited feelings of self-efficacy, an increased ability to articulate and express their new selves, and an ability to look toward the future, and they to start to implement some of the skills they rehearsed through theatre. They have also expressed a feeling that the collaborative group process, inherent in the performative process, has led to deeper collective consciousness and mutual respect for one another (Gardelli & Campana, 2009). Theatre work for the brain injury survivors allows for a discovery of new skills and assets and new and named identities, created by the survivors and not thrust upon them by outsiders who have a difficult time seeing beyond the disability. Staff at Framnäs have now been trained to continue the drama work. They communicate with Campana regularly so that changes in student population, issues faced, and students' concerns and needs always guide the work.

Stairway: Fighting the Sex Trafficking Industry in the Philippines

The Stairway Foundation, founded in 1990 by performer and artist Monica Ray and social worker Lars Jorgensen, is a nongovernment organization in the Philippines committed to seeing endangered street children realize their abilities, hopes, and dreams (www.stairway-foundation.org). Stairway advocates for the protection of children by offering education and training programs for social workers, teachers, caregivers, and law enforcement all over the Philippines and in four other counties in Southeast Asia. Stairway also has a residential program, which serves around 15 male youths who have been rescued from the sexual trafficking industry or who have been sexually abused. Located on an island off the coast of Manila, the group uses the metaphor of stairs to discuss the upward and forward journey their students experience. The children who live there have lived a significant time on the streets and as a result have sometimes spent time in institutions, been exposed to prolonged drug abuse, and are malnourished and often injured. The boys who are in the program work together as a cohort from the time they enter the program. This intentional alliance fosters a team-like attitude of trust, cooperation, and support.

Residencies are 1 year long and include classes on nutrition, health, and hygiene, reading, writing, English language, woodworking and other visual art abilities, and drama

(Gallagher, 2007). In addition to studying drama as a group, Stairway students and alumni perform in plays that seek to educate the public about abuse, human trafficking, and street life. In one example, *Cracked Mirrors*, written collectively by former students and Ray, audiences see the repercussions of child sexual abuse and exploitation. This particular play, which incorporates, rap, song, and monologue, has been performed across the Philippines and in Europe for a wide variety of audiences, including law enforcement personnel, women and children living in protection centers, boys and girls in schools, and at Stairway for the newer residents. Anonymous surveys of 446 audience members from nine different performances have indicated that the performance is “effective in raising awareness and breaking the silence around child abuse and exploitation” (O’Neill, 2007, p. 2). Stairway students and founders, as well as the many graduate students who have lived at the school for prolonged periods of time to study the program, cite the ability of drama to “capture emotions, personal experiences and other people’s points of view” (p. 11) as key factors of the success of this particular production.

Another play, a musical titled *Goldtooth*, utilized children and youth from the streets of Manila as actors. *Goldtooth* delivered a message to audiences about the prevalence and repercussions of abuse, but the play also taught the participants how to work together to create a well-written story, produce a play, and perform in front of an audience. In her doctoral dissertation, Belen Calingacion (2001) discusses how the young actors were transformed by the group experience, which simultaneously documented their experiences and advocated for their cause. “Theatrical intervention” she writes, “is seen here as a communicative strategy for personal and consequently, social development” (p. 15). By working together to create and perform in *Goldtooth*, street children were empowered to “negotiate a sense of who they are, realize their capabilities, and make . . . choices to live productive lives” (p. 14). Calingacion found that children who participated in the play were significantly less likely to return to the street. And by seeing these issues through the performing arts, audiences are confronted with the realities of street life and child sexual abuse. Particularly, because of one Stairway’s main goals is to break the silence surrounding these issues, theatre was a perfect tool. Through the group process, the young participants discovered that they were not alone, and not only was their shared experience comforting, it also allowed for a collective conversation about how to tackle issues around abuse. Stairway’s combination of counseling, group drama workshops and collaborative performances, and exposure to life skills has empowered the students of Stairway to break the pattern that often occurs among abused and exploited children. These diverse examples of popular theatre in action demonstrate the combined power of group process and performance for both personal and social transformation.

FUTURE DIRECTIONS

The linkages among participatory research, popular education, popular theatre, and social group work expand and enrich future directions and possibilities for social work practice. In this section, we discuss a number of ways their interconnections open up new thought and practice in social work.

Creating Connections

The profession has much to gain from making disciplinary connections between social work and theatre. The work of Framnäs Folkhogskolan and Stairway, as well as the techniques

in Theatre of the Oppressed, prompts us to ask, “How might group work practice be transformed by opening a space for dialogue between social work and theatre?” and “How might we reconceptualize practice through the lens of performance?” For example, William Schwartz (1994) describes rehearsal as an integral part of the group process wherein participants try out new interactions in the safety of the group. We saw that in Theatre of the Oppressed work and the Neurolinje theatre program, participants not only rehearse the way they would like things to be, but they also create a dramatization of things they might do to bring about the change, and they explore results of the proposed changes. Boal (1992) often referred to Forum Theatre as a way to rehearse for reality, and it is this potential for multiple solutions sought through a collective process that gives participants a fuller experience of their predicament and potential solutions; in this way, group members learn vicariously from the work of others. We propose that social work can be “enlightened and enlivened” (Williams, 1996) by incorporating popular theatre techniques, thus bringing “it closer to the lifeworld of disadvantaged communities” (Houston et al., 2001, p. 292). The integration of creative thought, group work, and rehearsing or practicing for change through popular theatre offers the democratic potential of problem solving and privileges the participants as the experts in the issues that affect their lives.

Rethinking Roles of Social Workers in Group Work

The philosophy and practice of participatory research, popular education, and popular theatre challenge us to reconsider the roles of the social worker in supporting group processes for consciousness raising and transformative action. We briefly describe three roles— animator, *bricoleur*, and joker—that we see as central to group and community practice grounded in the values, philosophy, and political commitment of popular participatory approaches.

The concept of animator “stresses the individual as a shaper of his or her own destiny” (Reisch, Wenocur, & Sherman, 1981, p. 115). The animator seeks to sustain action through facilitative skills that recognize the power of groups coming together to create change. The ultimate goal of animation is the liberation or empowerment of oppressed and marginalized people or groups. Thus the social worker as animator acts as a catalyst to spark consciousness that informs action and to facilitate the social relations and material conditions that enable people to act. Animators open up possibilities for meaningful participation; pose critical questions; coach participants through the processes of risk taking, skill building, and rehearsal; and validate their contributions. Animators do not impose problem definitions and directions for action. Rather, they encourage and nurture people’s critical reflections on their own reality, validate the wisdom of lived experiences, and help people envision and plan their own journeys.

French anthropologist Claude Levi-Strauss defined a *bricoleur* as a “Jack of all trades or a kind of professional do-it-yourself person” (1966, p. 17, as cited in Denzin & Lincoln, 1994, p. 2). He saw people as *bricoleurs*, that is, cultural beings with the wherewithal, imagination, and sense of discovery and possibility needed to adapt and transform human and material resources in response to new challenges. We find the image of the *bricoleur* helpful in imagining the transformed role of the social worker engaged in participatory process of investigation, education, and action. The role of *bricoleur* speaks to the creative, contextual, and culturally grounded practice of participatory, justice-oriented group and community work. The *bricoleur* is in ongoing engagement with other participants and with the resources and circumstances at hand to expand spaces of hope and invent new possibilities for action. Through participatory processes of education and action, the social worker

also encourages participants to see themselves as *bricoleurs* and engage accordingly. The practice of popular theatre is, in effect, a practice of bricolage. Participants literally sculpt their vision of existing realities and possible alternatives. Drawing from the collective wisdom of the group, they reframe problems and possibilities and create new meanings from the resources at hand.

In the Theatre of the Oppressed, the master of ceremonies is known as the “joker.” “The term derives from the joker (or wild card) in a deck of playing cards; just as the wild card is not tied down to a specific suit or value, neither is the Theatre of the Oppressed joker tied down to an allegiance to performer, spectator, or to any interpretation of events” (Schutzman & Cohen-Cruz, 1994, p. 237). When assisting the participants in the creation of plays or short workshop scenes, the joker does not mandate content, narrate story, or offer solutions; rather, she facilitates dialogue by providing a process and by encouraging the participants to think critically about the nature of the situation illustrated. The joker serves as the link between actors and spectators, providing commentary for the unfolding drama and inviting response and intervention. A joker avoids actions and statements that could sway or manipulate the participants’ conclusions and subsequent actions. The job of the joker is to smooth the participants’ progress and to keep the group on the track toward achieving critical consciousness. This characteristic of the Theatre of the Oppressed can be utilized outside of the theatrical arena; the joker can serve as a model for social workers interested in working with groups to facilitate participatory processes of planning, rehearsal, and action.

Transformative Possibilities

As Gutierrez, Reed, Ortega, and Lewis (1998) discuss, group work is critical to a transformative practice. Throughout this chapter, we have argued that participatory research, popular education, and popular theatre are fundamentally group processes that embrace social work’s commitment to social justice and create possibilities for social transformation. They bring a community dimension to group work and make specific links to social justice (Breton, 2012). We contend that the practice of group and community work can be strengthened through ongoing critical engagement with these possibilities. As Lewis (1988, p. 217) articulates, community work is group work and group work is the location “in which the integration of personal and social foci can take place.” The diverse examples we have highlighted here demonstrate the power of group work to build knowledge, raise consciousness, and create change. Furthermore, they illustrate the potential for creative interdisciplinary collaboration in utilizing group process to promote personal and social transformation. We have the knowledge and resources at hand to claim the best of social work’s history and revitalize the practice of group and community work in dialogue with others. To do so, we must move outside our comfort zones, stretch the boundaries of our professional knowledge base, and become engaged learners. Can we muster the courage, will, and humility to transform our practice and ourselves in the process?

NOTE

1. There is a broad literature on participatory research, participatory action research, and community-based participatory research. We use the umbrella term *participatory research* throughout this discussion. We refer readers to Lawson, Caringi, Pyles, Jurkowski, and Bozlak (2015) for an excellent, concise overview of participatory action research, its history, and principles.

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CHAPTER 26

Social Action Groups

LEE H. STAPLES

This chapter situates social action within community organizing, distinguishing it from other methods, such as community development. Social action groups can be organized around different arenas, including *geography, faith, issue, identity, shared experience*, and *work-related* domains (Staples, 2004, 2016). Regardless of the arena, small groups are the primary vehicles through which community members engage in social action. Examples include organizing committees, house meetings, issue committees, negotiating teams, lobbying committees, leadership development workshops, popular education sessions, and small groups for a variety of other organizational functions. Individuals typically are involved in social action groups as members, leaders, and/or organizers, with particular responsibilities and challenges attendant to each role.

COMMUNITY ORGANIZING

Community organizing entails collective action at the grassroots level to address common problems and to bring about social change. There is an extensive literature on organizing, community organization, and community practice (Alinsky, 1971; Bradshaw, Soifer, & Gutiérrez, 1994; Checkoway, 1995; Delgado, 1997; Delgado & Staples, 2013; Fisher, 1994; Fisher & Shragge, 2000; Gutiérrez & Lewis, 2012; Hyde, 1986; Ohmer & Brooks, 2013; Pyles, 2014; Reisch, 2013; Rothman, 1968, 1995, 2008; Rubin & Rubin, 1992, 2008; Sen, 2003, 2013; Staples, 1984, 2004, 2016; Weil, 1996). In much of this literature, community organizing is used interchangeably with a number of concepts, including advocacy, citizen participation, coalitions, community development, community economic development, planning, political action, program development, social action, and social movements. There are important differences in how assorted writers define and operationalize these practice modalities. It is not within the scope of this chapter to explore this conceptual variance. For purposes of this discussion, I distinguish between two primary organizing approaches that are included in this list: social action and community development. In my opinion, the other concepts transcend, partially overlap, are distinct from, or are subsumed under community organizing.

Community Organizing Approaches

Social action brings people together to convince, pressure, or coerce external decision makers to meet collective goals either to act in a specified manner or to stop or modify certain activities (Mondros & Staples, 2008; Staples, 2004, 2016). This approach operates from the basic assumption that community members are disadvantaged or oppressed and that most of their problems are products of social injustice (Freire, 1968, Alinsky, 1971; Bobo, Kendall, & Max, 2010; Checkoway, 1995; Kahn, 1991; Pyles, 2014; Rothman, 1968, 1995, 2008; Sen, 2003; Staples, 1984, 2004, 2016). There is a further assumption that attempts to bring about social change—thus altering relations of power—will be met by resistance from decision makers in powerful institutions (Delgado, 1986; Fisher, 1997; Hanna & Robinson, 1994; Rothman, 1968, 1995; Sen, 2003; Staples, 1984, 2004, 2016). Therefore, collaborative strategies will not be effective until or unless the parties share a greater degree of consensus. Rather, organized collective action and self-advocacy (social action) will be necessary for the affected community members to develop the requisite power to change the behavior and actions of external decision makers. Depending on the degree of difference, organized community members will be required to employ either persuasive campaigns to convince decision makers to support their goals and objectives or adversarial contest approaches to pressure and coerce concessions (Netting, Kettner, & McMurty, 2001; Netting, Kettner, McMurty, & Thomas, 2011; Warren, 1969).

Community development, on the other hand, involves participants in constructive activities and processes to produce improvements, opportunities, structures, goods, and services that enhance the quality of life and build member capacities (Mondros & Staples, 2008; Staples, 2004, 2016). There is an assumption that problems can be addressed successfully by strengthening relationships among community members and bringing people together to work cooperatively for common interests (Fisher, 1994; Pantoja & Perry, 1998; Rothman, 1968, 1995, 2008; Rubin & Rubin, 1992, 2008; Shragge, 1997). Self-help is central to this approach. If external institutions are engaged in change efforts at all, then collaborative or mildly persuasive campaign strategies (Netting et al., 2001, 2011; Warren, 1969) can be employed to enlist their assistance in cooperative activities.

Despite these important differences, both community organizing approaches share a number of common features, including the involvement of large numbers of the affected constituency taking action on their own behalf, the exercise of “people power” to resolve shared problems, a commitment to participatory democracy, the central role of indigenous leadership, the importance of developing effective organizational structures as vehicles for ongoing social change, and a dual emphasis on inclusive processes and successful outcomes.

Community Organizing Arenas

Many community groups are organized to represent the interests of everyone living in a distinct geographical area—a neighborhood, a municipality, or even a whole region. Usually, such groups would address a range of community concerns, which might include housing, education, recreation, employment, environmental issues, transportation, or health care. The key is that the *turf* issues addressed are shared by members of a specified geopolitical locale. So, for instance, the Coalition for a Better Acre is organized in the lowest income neighborhood of Lowell, Massachusetts, a blue-collar industrial city still suffering the effects of a declining industrial base. Many of the residents of the Acre are either Cambodian or Dominican. These very disparate ethnic populations have joined together to improve their neighborhood, taking social action for more affordable housing, the creation of youth

programs, and cleanup of the abandoned canals, once utilized to transport goods to and from the many vacant textile factories within or nearby the Acre.

Legendary community organizer Saul Alinsky (1971) developed an organizing model that brought together preexisting groups to form an “organization of organizations” in the Back of the Yards neighborhood in Chicago. Later, he founded the Industrial Areas Foundation (IAF) to train community organizers to replicate the model in communities across the United States. Religious organizations are key components of this organizing model, and today, the IAF describes itself as “the nation’s largest and longest standing network of local faith and community-based organizations” (www.industrialareasfoundation.org). For instance, along the Texas–Mexico border, IAF organizations have won major improvements in the infrastructure for *colonias* located in unincorporated areas, including fresh drinking water, waste water removal, trash collection, and construction and repairs of roads. Variations of this organizing model are utilized across the United States by *faith-based* organizations that include the PICO National Network, Gamaliel Foundation, Direct Action and Research Training Center (DART), Gather the People, Call for Action, Catholics for Free Choice, and the Muslim Peace Fellowship.

A third way that community groups can be organized is according to a particular *issue* focus that transcends a turf area, such as environmental justice, affordable housing, clean elections, tax reform, health care, or education issues. GreenRoots in Chelsea, Massachusetts, is involved in a wide variety of social action campaigns and community development activities related to *environmental justice issues* that are in multiple areas of the city, including organizing against corporate polluters, supporting a community garden, restoring the city’s only salt marsh, establishing environmental education programs, stopping construction of a dirty diesel power plant within 1,500 feet of an elementary school, and fighting for resident involvement in the city’s planning process for development along Chelsea Creek. *Affordable housing* provides another example of the issue arena. Over the past three decades, nonprofit community development corporations (CDCs) have taken a developmental approach to produce impressive numbers of affordable housing units across the United States. On the other hand, community-based organizations have employed social action strategies and tactics to resist the loss of affordable housing due to gentrification, displacement, abandonment, arson, and predatory lending practices leading to foreclosure.

A fourth dimension is *identity*, for instance, race, ethnicity, gender, sexual orientation, or physical or mental disability. Identity organizing around race, ethnicity, and gender has been well documented (Collins, 2000; Daley & Wong, 1994; Delgado, 1997; Gutiérrez & Lewis, 2012; Hyde, 1986; Joseph et al., 1991; Pyles, 2014; Sen, 2013). Identity politics also has animated the LGBTQ and disability rights movements (Chamberlin, 1978; Marcus, 2002; Rimmerman, 2002; Stroman, 2003). M-POWER (Massachusetts People/Patients Organized for Wellness, Empowerment, and Rights) is a member-run social action organization for deinstitutionalized mental health consumers. M-POWER has conducted successful campaigns for a Mental Patients’ Bill of Rights, guidelines for the use of seclusion and restraints in mental hospitals, and creation of an informed consent policy for psychotropic drugs.

Community organizations frequently bring people together around *shared experiences* such as being homeless, tenants, homeowners, students, single parents, recipients of public assistance, or immigrants. The Latino Immigrant Committee in Chelsea, Massachusetts, is composed primarily of recent immigrants from El Salvador, Honduras, Guatemala, Colombia, Chile, and Nicaragua. A core group of 30 people is most active and engaged in social action focused on: discriminatory treatment at the local branch of the post office, immigrant

rights, prevention of gang violence, recovering personal funds lost through scams targeting non-English speakers, and increased participation in the political process. I also include organizing based on one's *age*, especially youth and elderly groups, as most accurately based on shared experience rather than identity. Certainly, both elements may lead members of various age categories to participate in collective action. However, one's identity usually is part of one's core essence over the course of her or his lifetime, while age changes during the life cycle. There are exceptions (e.g., when a transgendered person makes the change in midlife or a person is challenged by a physical or mental disability that she or he didn't experience at an early age), but this age distinction usually is helpful for analytical purposes.

A sixth arena includes *work-related* community organizing efforts that are not done exclusively by labor unions. In some instances, community-labor coalitions may be formed, such as the high-profile "Fight for \$15" campaign that has mobilized thousands of low-wage workers and supporters across the United States. In other cases, social action may entail efforts to establish a municipal living wage, raise the state minimum wage, or secure funding for youth summer jobs. There also has been a dramatic increase in the number of immigrant workers' centers in both rural and urban areas (Reynoso-Vallejo & Staples, 2013). Immigrant workers, especially those who are undocumented, routinely are exploited in many workplaces. The problems may include unsafe conditions, illegal payment below the minimum wage, sexual harassment, "wage theft" (e.g., extra payroll deductions, unpaid overtime, refusal to pay back wages), shifting work schedules, unfair termination, job insecurity, and intimidation. The centers have been established to inform immigrant workers of their rights, to provide support, to raise consciousness about systemic oppression and discrimination, and to mobilize participants for collective social action to address particular issues and unjust situations.

Of course, these six arenas are not mutually exclusive, and they may overlap. Youth-led organizing efforts may address environmental justice issues, be focused on concerns resulting from shared experiences as students in a local high school, or enter the work-related arena to target the state legislature for increased funding for youth employment programs. Low- and moderate-income homeowners living in the same turf neighborhood may be facing foreclosure due to predatory lending practices by several banks in the area; they may organize as a local affiliate group to join a larger social action issue campaign fighting for banking reform. The possibilities for mixed arenas are numerous; however, an awareness of these distinctions is very useful when examining and analyzing different types of community organizing efforts.

SMALL GROUPS AND SOCIAL ACTION

Although social action may engender images of enormous meetings, rallies, and demonstrations, small groups and committees are the primary medium through which this type of organizing takes place (Gutiérrez & Lewis, 1997, 2012; Staples, 2004, 2016). The group setting is an ideal access point for most community members to engage in social action. Small groups maximize opportunities for participation in processes of discussion, analysis, consciousness raising, decision making, and planning. They provide a vehicle through which people can become more actively involved in organizational work. Usually, for every event with a large turnout, many smaller meetings are held for a range of purposes, including action research, leadership training, popular education, executive decisions, strategic analysis, community education, recruitment, action planning, negotiating, lobbying, and evaluation. An illustrative, but not exhaustive, set of examples follows.

Organizing Committees

The organizing committee (OC) is a time-tested mechanism for overseeing and conducting an initiative to build a new organizational structure or to revitalize an existing one. Ideally, 12–15 people who are well-respected opinion leaders will form such a committee, legitimating the organizing effort, neutralizing potential opposition, examining possible issues, actively recruiting new members, and providing a consistent leadership core (Staples, 1984, 2004, 2016). Formation of an OC establishes a structure for decision making, which is especially important before a new organization has been created. Individuals who actively participate in an OC are much more likely to develop a sense of ownership and investment in the organizing process. The OC also becomes a forum for leadership development while increasing opportunities for both individual and collective empowerment.

It's important to make sure that OC members actively commit to work directly in the recruitment activities. If they are well known and have good connections with many community members, they will be in a strong position to recruit new members, helping to ensure that the effort gets off to an excellent start. Clearly, the formation of an organizing committee during a first membership drive is designed to develop an action group, a leadership cadre that is willing and able to “own” the organizational structure that soon will follow. However, because community organizations should do regular systematic member recruitment and outreach to replenish their numbers, to identify potential new leaders, to discover fresh issues, and to reconnect with their constituency, variations of organizing committees can be found regularly overseeing this activity with well-established groups.

House Meetings

These are small meetings (5–15 people is a typical attendance), which may be held in someone's home or in a familiar place such as a church/temple/mosque, school, library, or human services agency. House meetings usually are utilized either for recruitment or educational discussion about complex or controversial issues. Attendees can be recruited by the person hosting (friends, neighbors, colleagues, relatives), by word of mouth, or by knocking on doors; but there is a conscious effort to limit the number. The small meeting size and comfortable, informal format are designed to maximize participation. A number of roles (welcoming, presenting information, facilitating discussion, securing commitments for further participation) can be divided, providing opportunities for emerging organizational leaders to develop experience, confidence, and skills.

A typical agenda for a house meeting includes introductions, discussion of the issues, explanation of the relevant community group, and recruitment to a meeting, activity, action, or event. Slide shows that focus on the relevant issue or project can be extremely effective as a catalyst for focused discussion and as a means of bringing the group's goals to life. The person hosting the meeting plays a key role, welcoming people as they arrive, making them feel comfortable, and engaging them in conversation. It is especially important to put the early arrivals at ease and to get them talking with one another. As the meeting begins, the host should handle the introductions and give a short enthusiastic rap about her or his own involvement in the group. The host and other new leaders should take responsibility for as much of the agenda as possible (Staples, 2007, p. 15).

For instance, the Franklin Hill Tenants Association in Boston held a series of house meetings in every building of their large (more than 300 families) public housing development. The house meetings were used to recruit new participants in a social action campaign to force the Boston Housing Authority (BHA) to improve maintenance and make repairs as

required by the state sanitary code. A slide show was employed to stimulate and focus discussion on a number of specific grievances. Slides depicted exposed wiring, leaky plumbing, crumbling walls, broken stairs, the lack of recreational facilities for youth, an empty basement space, unsecured common hallways, and a number of abandoned apartments that had become havens for drug dealers and violent gangs. The slides served to “rub raw the sores of discontent” (Alinsky, 1971), and both tenant leadership and organizing staff were quick to channel the attendees’ dissatisfaction into discussions about taking collective action to confront the Housing Authority.

A spirited social action campaign evolved from these preliminary house meetings, and ultimately the tenants’ group successfully pressured the BHA to make a number of changes. Repairs were made to individual apartments, a twice-weekly trash pickup was instituted, a youth program was developed, vacant units were rehabilitated and filled, locked doors to common hallways were put in place along with a buzzer system, and the basement now houses a child care program during the day and a range of community activities in the evenings.

Issue Committees

Often, members of social action organizations will have a variety of concerns relating to the institutions, organizations, and decision makers that affect their lives. A range of possible campaigns may exist, and the organization will need to choose new issues carefully and strategically. Issue committees can help meet this organizational need; typical activities include prioritizing goals, selecting new issues, conducting action research, engaging in strategic planning, developing action plans, implementing direct action, and evaluating the results.

Social action organizing entails aggregating and politicizing individual problems and then “cutting” issues from the fabric of shared problems (Staples, 1997, 2012). As defined by *Webster’s New World College Dictionary*, a problem is “a question, matter, situation or person that is perplexing or difficult” (Agnes, 2000), whereas matters “at issue” are “in dispute.” Essentially, problems are broad concerns that generate dissatisfaction but not necessarily *action*. On the other hand, issues encompass controversial, and often competing, courses of action to address a problem or aspects of it. Thus the lack of affordable housing in a low- and moderate-income area may be a *problem*, whereas possible social action *issues* that could be cut might include the establishment of rent control, a housing trust fund, a condominium conversion ordinance, inclusionary zoning, a development linkage program, low-interest mortgages, creation of new housing, or expansion of subsidized housing. Depending on how the issue is cut, different parties will have positive or negative self-interests and will be more likely to engage in social action either as proponents or opponents. Identifying, prioritizing, and selecting issues often takes place in small social action groups or issue committees.

Many years ago, Cox (1991) offered a number of reasons that these groups are optimal for this activity, and her words still are very relevant:

Small groups of individuals of like status provide a medium in which members can sort out the personal from the political aspects of their problems. Empowerment groups are helpful to individuals coping with and changing the internalized aspects of oppression/powerlessness in the following ways: (1) The group as a whole, through sharing experiences, can better describe the full impact of specific problems of the members’ lives and the lives of their families and friends; (2) Members who have survived or overcome aspects of powerlessness

can inspire and motivate others; (3) Members who have identified beliefs and/or behaviors of their own which reinforce their own oppression (i.e., belief that they cannot learn valued skills, are incapable of achieving higher status roles, or cannot have an impact on a social service agency), can confront their peers and in so doing facilitate the consciousness raising process; (4) Groups can provide a forum in which individuals can gain increased knowledge on the political dimension of their situation, and a better understanding of the origins of the personal dimensions of their problems. (p. 82)

When prioritizing goals and choosing a new issue, a strategic analysis helps committee members assess the potential for simultaneously winning a victory and developing organizational capacity. Questions that serve this analysis for social action groups follow (Staples, 2012):

- Is the issue consistent with the long- and middle-range goals of the organization?
- Will the issue be unifying or divisive?
- What is the group's capacity to undertake this issue campaign at the present time?
- Will the campaign help the organization grow?
- Will the campaign provide a good educational experience for leaders and members, developing their consciousness, independence, and skills?
- Will the organization receive credit for a victory on the issue, improve its credibility, and increase its overall visibility?
- How will the campaign affect organizational resources?
- Will the campaign develop new allies or enemies?
- Will the campaign emphasize collective action, producing new strategies, tactics or issues?
- Will the campaign produce a significant victory?

Action research on issue campaigns should not be the sole purview of professional staff. It is important to demystify and democratize information that, from an elitist perspective, may seem highly technical, esoteric, privileged, and beyond the intellectual grasp of average community members. When leaders and activists are involved in participatory action research (Chevalier & Buckles, 2013; McIntyre, 2008; Minkler & Wallerstein, 2008), they quickly develop even more ownership of issue campaigns and become more sophisticated about “handles” that can provide leverage on institutions that the group is trying to influence. Working as a committee to sift through background material, read relevant news articles, study official reports, gather statistical data, learn about regulatory processes, and research the law can be very empowering for organizational leaders, enhancing their knowledge, increasing their confidence, and raising their consciousness. The group process enables a more natural division of labor, with members taking on responsibility according to their interests and talents. Discussion and dialogue among group members also supports the learning process.

Strategic planning is a natural outgrowth of action research. Strategies are overarching systematic plans to achieve organizational goals, whereas tactics are specific methods, procedures, and techniques employed to carry out those plans. Warren's (1969) classic framework continues to be recognized as the definitive guideline for selecting the most effective strategic and tactical approach. Warren's basic operating principle holds that the level of agreement or disagreement between two parties is the key variable for determining the best strategy and tactics. For instance, when a community group reaches a consensus with an external institution, collaborative methods associated with community development will be most

productive. If a difference of opinion exists but the potential is there to change the views of an institutional target, a persuasive campaign will be the best strategic option. Here the lines often blur between a community development approach (gentle persuasion through education or appeals for assistance; usually positive incentives) and social action (pressure to “do the right thing”; occasionally positive incentives, but often negative sanctions such as bad publicity, public embarrassment, loss of votes, loss of business, disapproval by significant third parties). And a contest approach will be necessary when the disagreement is so basic that the community group has no realistic possibility of winning over an institutional target.

The Raise UP Massachusetts (RUM) social action campaign in 2013–2014 is instructive. RUM is a community–labor coalition that won passage of the highest minimum wage and the strongest earned paid sick time laws in the country. The first part of the campaign entailed a successful state legislative initiative that affected over 575,000 people by raising the minimum wage from \$8 to \$11 per hour over a 3-year period, starting January 1, 2015. The second part required a ballot referendum that resulted in a 59–41% statewide vote to pass a bill giving almost 1 million workers (who until then had no *paid* sick time) the right to earn 1 paid sick day for each 30 hours they worked—up to a maximum of 40 days.

As many as 30 community, faith-based, and labor groups participated in regular meetings over the course of the campaign, and another 30–40 groups also collected signatures to put the paid sick time measure on the ballot. The RUM coalition featured an executive committee that coordinated activities, strategic planning meetings, subcommittees, regional training sessions on signature gathering, and leadership development workshops. In the spring of 2015, the participating groups voted to continue the coalition due to the previous positive experience working together, the trust established, and the need to address other *work-related* issues. Goals include higher wages for fast-food workers and employees of large retail stores, legislation for paid family medical leave in cases of serious illnesses, and raising taxes progressively on wealthy residents to support necessary programs.

Lobbying Committees

Legislative lobbying goes hand in hand with social action at the municipal, state, and even national levels. Public officials are quick to recognize the potential voting power of organized community members. As Judy Meredith (2000, p. 4) notes, “Elected and appointed decision-makers make different decisions when watched by the affected constituents,” and “Lobbying is simply getting the right information to the right person at the right time.” Large numbers of organized people go right to the heart of the self-interest of public officials. Typically, the larger and better organized the group is, the greater the positive results secured.

For instance, the Greater Boston Interfaith Organization (GBIO) conducted a successful social action campaign to convince the Massachusetts state legislature to establish a \$100 million trust fund to build affordable housing over a 5-year period. First, GBIO gathered more than 100,000 signatures on a petition to increase the state’s funding for affordable housing. Next, the group held 11 “accountability sessions” in legislative districts in which hundreds of constituents pushed elected officials to make a commitment to support legislation establishing an affordable-housing trust fund. Following these local sessions, a huge rally with more than 3,000 people present pressured the state legislative leadership to commit to moving the legislation through both House and Senate. And, finally, small, well-informed constituent groups lobbied their elected representatives to support the legislation. This last step—small groups directly interacting with their own representatives—was

crucial to the success of this campaign. And, as discussed previously, each of the prior steps—gathering signatures, holding local accountability sessions, and conducting the large rally—was preceded and followed by numerous small-group planning and evaluation sessions.

Negotiating Teams

At times, social action may be designed to get the group to the bargaining table. In other instances, opponents may offer to negotiate, but such proposals may be made in good or bad faith. Splain (2016) has offered guidelines for determining whether or not community groups should engage in formal bargaining. He also lays out seven areas of planning, preparation, and training that should precede any negotiating session. These ground rules help clarify and establish the relationship between the bargaining committee or negotiating team and the larger social action organization:

1. The organization must determine the general makeup of the bargaining committee, as well as the specific election or selection process.
2. The organization, not just the bargaining committee, must reach consensus on the time limit allowed for bargaining to achieve its purposes before the membership reevaluates the basic decision to engage in negotiations.
3. An accountability mechanism must be established through which the committee will keep the membership informed on an ongoing basis and, on occasion, seek votes on various bargaining positions.
4. The basic formalization of demands and possible bottom lines is established by the membership, but the specific details of both are drawn up by the committee.
5. The question of nonbargaining campaign activity, such as use of the media during the negotiation period, should be resolved by the bargaining committee with input from the membership.
6. The committee must devote one or more preparatory sessions specifically to role-playing, research, and record-keeping skills.
7. The committee must discuss and agree on specific roles for each individual member to play, including the organizer, as well as the use of caucuses for decision-making purposes.

Once issues of representation, mandate, responsibility, accountability, and roles are resolved, the negotiating team will be empowered to move forward with the bargaining process.

For instance, a group working to preserve and expand affordable housing might contest the development of 200 units of new high-end housing on a vacant land parcel located in a low-income neighborhood. Fearing gentrification, the group might launch an effective direct action campaign targeting both the developer and the city's redevelopment authority. Press coverage for the campaign might be quite favorable, and a number of allies might lend their support, including the area's state representative. Eventually, the redevelopment authority might yield to the public pressure and convince the developer to come to the table with representatives from the social action group to discuss the possibilities of setting aside a significant number of affordable units. A negotiating team from the affordable housing group would be empowered to bargain on behalf of the full membership, consistent with the accountability guidelines presented above. The process might entail multiple negotiating sessions over a

period of several months, as the team keeps the whole group informed and involved (albeit one step removed) in the negotiating process until a favorable settlement can be reached.

Leadership Development

Community organizing places great emphasis on the development of leadership from within the affected constituency. Most grassroots leaders develop their abilities through direct experience, as they carry out their roles and responsibilities and then reflect on that experience through a process of *praxis*. Kieffer (1984) examined personal empowerment for emerging leaders in grassroots organizations, which he described as “a necessarily long-term process of adult learning and development” that results in increased “participatory competence.” In a qualitative study of 23 highly successful leaders from 15 grassroots groups, Boehm and Staples (2005) found that 21 of these individuals attributed informal learning gained through firsthand experience as the single most important factor in the development of their own leadership capacities, critical consciousness, and commitment.

Nevertheless, both social action and community development groups frequently hold workshops and training sessions to develop organizational skills, as well as critical analysis about the inequitable distribution of wealth and power in society, knowledge about the dynamics of oppression, and an understanding of collective action as a means to bring about social change. Common topics include basic principles of organizing, the distinction between leader and staff roles, power analysis, participatory action research, recruitment techniques, holding one-on-one/relational meetings, community building, mentoring less experienced leaders, conducting effective meetings, conflict resolution, strategic analysis, action planning, direct action tactics, countertactics of opponents, negotiating skills, working with the media, fundraising, information technology, building coalitions, and organizational development.

It also is essential to move beyond only organizational skills training to develop the capacity for critical consciousness (Breton, 1995, 2004; Burghardt, 1982, 2011; Carroll & Minkler; 2000; Gutiérrez, 1995). Popular education methodology (Freire, 1973) entails the process of *conscientization* through which grassroots leaders can reflect on their own experiences, recognize common problems shared with other group members, raise awareness about systemic oppression, and develop plans to engage in collective action for social change. The strongest leadership development programs combine practical skills, personal growth, participatory competencies, consciousness raising, popular education, democratic principles, and strategies for collective empowerment (cultural, political, economic). And most formal training and education takes place in small-group settings in which participants easily can share experiences and insights, learning from one another, as well as from those leading the sessions.

Small groups are utilized by social action organizations for a variety of other functions, including media teams, long-range planning, grassroots fundraising projects, special events (conventions, annual meetings, candidates’ nights, festivals, etc.), developing bylaws, officers’ meetings, nominating committees, hiring staff, and evaluating virtually every aspect of organizational activities.

MEMBERS, LEADERS, AND ORGANIZERS

People may be involved in social action groups as members, leaders, or organizers, with distinct roles and responsibilities for each. The role of *members* can vary from mere followers who take directions from the group’s leadership to active participants in all group decisions

and actions. And, of course, there can be wide variation in the degree to which individuals take part in the group, from regular to more casual participants. *Leadership* forms can range from a single individual who is in charge of all group affairs to several people who share different roles to collective models in which theoretically all members are leaders. Leadership may be formal or emergent, and individuals may be first- or second-line leaders. Although leaders typically are out front guiding, directing, or showing the way for followers, when an individual is functioning as an *organizer*, she or he is enabling other group participants to take on more responsibility (Staples, 2004, 2016). Many social action groups formally acknowledge the role of organizer through paid staff positions. However, the same person may function as a leader-organizer and compensation may not always be provided for this role, especially with organizations based in communities of color (Delgado, 1997; Sen, 2003). Challenges associated with each of these three functions in social action groups are explored below.

Members

Ensuring the active participation of group members always has and always will be a fundamental challenge for social action organizing. Large numbers of active participants are the primary means by which group goals and objectives are accomplished; the power of numbers is harnessed through an organizational structure to bring about social change. However, the involvement of community members also is an end in itself, giving participants ownership of decisions and processes, developing and deepening relationships, promoting active involvement, and building group solidarity. The most successful groups will have a commitment to enlisting new activists and a recruitment technology that may include knocking on doors, targeted home visits, house meetings, networking, presentations to various “captive audiences,” community forums, phone calls, emails, texts, websites, Facebook, Twitter, Skype, leaflets, PowerPoint slides, posters, and newsletters (electronic or paper). The group should be inclusive and reflective of the potential participants with regard to race, ethnicity, religion, age, gender, social class, sexual orientation, citizenship status, and physical or mental ability. It will be useful to analyze involvement along dimensions of both breadth and depth—how many people are participants and how actively they are involved.

Although social action groups always have competed for people’s time, a number of phenomena make this challenge even more difficult in the context of the current economy and culture in the United States (Burghardt, 2011; Pyles, 2014; Reisch, 2013). Today, more people than ever before are working more than one job just to make ends meet (Ehrenreich, 2001), and this economic reality leaves them with both scarce time and limited energy to engage in social action. This situation is compounded by increased individualistic behavior and a general decline in community involvement (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Putnam, 1995). Yet, in spite of these barriers, there has been a dramatic rise in social action organizing over the past several decades (Delgado, 1997; Delgado & Staples, 2013; Marcus, 2002; Mondros & Staples, 2008; Pilisuk, McAllister, & Rothman, 1997; Rimmerman, 2002; Stroman, 2003), much of it concerning issues of social identity, culture, and economic self-interest.

During this same time frame, geographical communities have become more multicultural, and within-group ethnic diversity has grown apace (Daley & Wong, 1994; Gutiérrez, Lewis, Dessel, & Spencer, 2013), creating new challenges relating to members’ differing expectations regarding group norms and processes. These differences can play out around a variety of issues, including but not limited to meeting sites, starting and ending times, whether children attend, provision of child care, if and when food is served, use of formal

agendas (with or without time limits), note taking, dealing with latecomers, gender and age dynamics, degree of formality, chairing styles, comfort levels with intragroup conflict, and decision making by consensus or voting. As groups establish their norms and procedures for these and other matters, a group culture emerges, providing the members with formal and informal guidelines for conducting their business. Such a culture offers security and direction for group members, but often at the expense of being open and welcoming to nonmembers. The particular challenge for social action groups in diverse settings is to build enough cohesion and shared culture to establish the requisite solidarity necessary to engage in adversarial organizing campaigns while remaining permeable enough for newcomers to enter and sufficiently malleable for these new members to influence that very same culture.

Social action itself raises particular issues for some recent immigrants. Many may be uncomfortable confronting government officials, based on their experience with political repression in their countries of origin. Noncitizens, especially those who are undocumented, may fear being singled out and deported, and the growth of anti-immigrant sentiment in the wake of the 9/11 tragedy, other domestic and international episodes, and the 2016 elections has done little to diminish these concerns. However, there are creative ways for dealing with these types of challenges.

For instance, the Chelsea Latino Immigrant Committee (CLIC) formed a community support committee for immigrant workers—many of whom were undocumented—at a meat processing plant at which numerous severe violations of basic health and safety regulations existed. The group linked with the United Food and Commercial Workers Local 1445, Jobs for Justice, and MassCOSH (Massachusetts Committee for Occupational Safety and Health) to organize a rally and march with more than 200 people. A delegation entered the factory and confronted management. After the rally, attorneys for the National Labor Relations Board (NLRB) interviewed workers, the Chelsea Health Department made inspections citing violations at the plant, and the state Occupational Safety and Health Administration (OSHA) became involved. Under threat of an NLRB lawsuit, the company instituted new health and safety policies, repaired or replaced some equipment, established safeguards to help prevent sexual harassment, and agreed to guidelines for fair treatment of workers. Subsequently, CLIC members helped form the Chelsea Immigrant Workers' Center, which has gone on to win numerous victories for undocumented workers concerning various forms of “wage theft” and unfair termination of employment.

Leaders

Bales (1970) identified two types of small-group leaders: those who provide instrumental leadership to accomplish the group's tasks, and those who are concerned with group processes and members' feelings (socioemotional or affective leaders). Bales also found that it is unusual for a single individual to provide both types of leadership. Yet both forms of leadership are essential for social action groups. Logically, several leaders, operating through a shared leadership model, provide a social action group with a range of strengths and areas of expertise that no one person can supply (Burghardt, 1979, 2011; Toseland, Jones, & Gellis, 2004). Groups with a shared leadership structure are in the best position to operate consistent with the principles of participatory democracy and can avoid overreliance on one or two individuals.

There also will be opportunities and incentives for new leaders to emerge and take on increasing levels of responsibility. Shared leadership is most possible when clear division of roles and responsibilities exist between first- and second-line leaders, as well as the full

membership. Essentially, a group's top leaders hold formal positions, such as president/chairperson, secretary, treasurer, or governance board member, whereas second-line leaders are neither elected to office nor appointed to head key organizational committees. They are core activists, who are regular participants in organizational meetings, activities, and events. Like "worker bees," they are industrious and indispensable for implementing the group's policies, procedures, and plans. They serve as links between the top leaders and the group's rank-and-file members, often infusing the group with energy, creativity, and fresh perspectives. New first-line leaders often come from their midst, and these individuals may offer a healthy challenge to long-term top leaders, who may have a tendency to become entrenched. This process helps democratize the group and serves as a preventative of "groupthink" (Janis, 1972), a phenomenon in which healthy questioning and dissent is squelched.

Indeed, Robert Michels (1949), in a classic piece on organizational behavior, termed the tendency for power to become concentrated in the hands of a few leaders the *Iron Law of Oligarchy*. Preventing this phenomenon from occurring remains a serious challenge for social action groups to this day (Staples, 2004, 2016). Oligarchic leadership often is vulnerable to co-optation and corruption. It also is contrary to the principles of participatory democracy, which is so intertwined with the power of numbers—the basic fuel of social action organizing. Second-line leaders help forestall (or slow down) the occurrence of oligarchic leadership. Therefore, it is essential to include these secondary leaders in any leadership training sessions in order to prevent this process from *widening* the gap (knowledge, skills, commitment) between the first-line leaders and the members. Whoever plays the role of organizer is responsible for finding and developing second-line leaders; the importance of this task in social action groups cannot be overemphasized.

Concern about the emergence of oligarchic leadership has led some groups, especially those committed to feminist principles, to experiment with collective structures that have no formal leaders. In another classic article, Jo Freeman (1973) described the "tyranny of structurelessness" as a phenomenon that usually occurs when unstructured or "leaderless" groups attempt to engage in social action. Freeman argued that the lack of formal leadership ensures that a group will be controlled by informal and unacknowledged elites, which are neither responsible nor accountable for carrying out tasks. Ironically, this attempt to mitigate problems created by too much structure usually results in the concentration of power in the hands of an informal oligarchy. Freeman concluded by offering some very sound principles for democratic structuring:

1. *Delegation* of specific authority to specific individuals for specific tasks by democratic procedures.
2. Requiring all those to whom authority has been delegated to be *responsible* to those who selected them.
3. *Distribution* of authority among as many people as is reasonably possible.
4. *Rotation* of tasks among individuals.
5. *Allocation* of tasks along rational criteria.
6. *Diffusion of information* to everyone as frequently as possible.
7. *Equal access to resources* needed by the group.

The appropriate use of permanent and temporary committees also helps balance a social action organization's need for both experience and new leadership. Long-term standing committees have the advantage of giving the organizational structure continuity and

stability; there is a minimal change in their membership over time. This relative permanence makes it possible for committee members to form a working team that can learn technical responsibilities together, such as finances, bylaws, or personnel policies, without constantly having to slow down while new activists master the learning curve.

Short-term ad hoc committees can be even more important, as they provide structural access points through which newcomers can become active. These temporary committees are suitable for issue campaigns, special events, or time-limited activities, and new participants often first get involved at this level. Having standing committees in these areas would make it more difficult for new people to plug in to a social action group's structure, because veteran activists might monopolize positions of influence and responsibility. The structural permeability of ad hoc committees keeps a steady flow of fresh "new blood" flowing into the organization, helping to prevent oligarchic concentration of power. Temporary committees also are suitable for projects such as developing a strategic plan, nominating new officers, or evaluating an organizational initiative, which may require members to have a higher degree of familiarity with the organization. But whether short-term committee members are veterans or newcomers, these structures exist for a specific purpose and are disbanded when their work is complete, helping to keep the group more dynamic and energized than standing committees, which may fall dormant between campaigns and projects, thereby contributing to organizational fossilization.

Organizers

When someone takes on the role of organizer, her or his primary responsibility is to engage community members to act on their own behalf. Organizers identify new activists and potential leaders, motivating them to become involved. They work closely with a social action group's leaders, supporting them as they develop both confidence and skills, preparing them for various organizational responsibilities. Organizers help leaders and members to formulate visions and goals, assist in developing strategies and action plans to achieve those ends, and facilitate processes to evaluate the results of the group's actions. They also work to develop organizational structures (e.g., committees, governance boards, task forces, coalitions) through which collective action can be taken. Organizers who do *not* do their jobs effectively often are *doing too much* for both members and leaders—making decisions, advocating, brokering, speaking publicly, and negotiating on their behalf. This builds dependency and stunts the growth of the constituency's own leadership. Organizers should not be directing the group's positions, policies, programs, projects, or procedures, for that is the prerogative of members and leaders. Rather, the role of organizer—whether formally recognized or not—is to work with the group to motivate, recruit, educate, enable, facilitate, and catalyze *others* to take collective action for social change.

If a social action group retains an organizer in a paid staff position, more or less emphasis will be placed on whether she or he shares the same characteristics as the group's members along dimensions such as race, ethnicity, religion, class, gender, sexual orientation, age, and physical or mental ability, depending on the group's interest domain and organizing arena. Frequently, groups that are organized along identity interests and some shared experiences (e.g., disabled people, single parents, LGBTQ, ethnic refugees) will prefer, although not necessarily require, staff who have similar personal traits or experiences. Members of social action groups organized along geographical lines, especially where a particular ethnic group predominates, often may favor staff of that ethnicity or residents of that community but may not feel as strongly as activists who focus on that very identity. For members of

most groups working with issue interests, the staff's "insider" or "outsider" status vis-à-vis the majority of members is far less relevant (Staples, 2000).

In all instances, regardless of similarities or differences with the constituency, it is crucial that organizers play a facilitative rather than a directive role. Although they may have a measure of expertise about the technology of building powerful social action organizations, they also will have much to learn from community members and leaders, especially if they are "outsiders." To the extent that they have knowledge to impart, organizers should take on the role of "teacher-learners" and relate to group members as "learner-teachers," as articulated by Paulo Freire (1973). Bradshaw and colleagues (1994) offered further guidelines that stand the test of time for organizers working with communities of color:

1. Develop a positive connection with the community.
2. Understand the minority community.
3. Develop self-awareness.
4. Build adequate leadership within the community.
5. Engender cohesiveness within and among communities of color.
6. Develop "cultural humility." (Tervalon & Murray-Garcia, 1998)

But, in fact, these principles can be adapted and applied to any organizer working with a social action group in any community. Indeed, each of the groups cited as examples in this chapter has paid organizing staff that generally subscribe to these guidelines, whether they are "insiders" or "outsiders."

Thus members, leaders, and staff members each have their own particular responsibilities and challenges in the various types of small groups that operate within larger social action organizations. When each party works at an optimal level, the groups may approach a "democratic microcosm" (Ephross & Vassil, 2005), operationalizing a set of values that include "the worth of each individual group member, active participation by each member, each member's responsibility for actions and behaviors, respect for differences of background, ability, and personal characteristics among the members, and an awareness within each member of responsibility, to some extent, for the entire group" (p. 44). At such times, these groups can perform both task and process functions successfully, and effective social action will be most possible.

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CHAPTER 27

Group Process Dynamics and Skills in Interdisciplinary Teamwork

LAURA R. BRONSTEIN
JULIE S. ABRAMSON

Interdisciplinary teams were introduced in the 1940s and have been heavily used in health and mental health settings since the 1960s and 1970s as a means to call on the specialized knowledge of different categories of professionals (Julia & Thompson, 1994). More recently, such teams have expanded in health and mental health settings and have developed in almost every setting in which social workers practice, including schools (e.g., Biggs, Simpson, & Gaus, 2010), child welfare (e.g., Burry, Shdaimah, Richardson, & Rice, 2011; Harr, Souza, & Fairchild, 2008), special education (e.g., Banach & Couse, 2012), adult protective services (e.g., Ernst & Smith, 2012), criminal justice (e.g., Bronstein & Wright, 2006), and other arenas in which client problems are complex and require varied expertise for their resolution (Bronstein, 2003; Payne, 2000; Proenca, 2000). The dynamic interaction of specialized professionals on teams is assumed to promote an “expanded level of thinking” (Julia & Thompson, 1994, p. 39) or “generativity” (Lawson & Sailor, 2000), resulting in more creative, comprehensive, and effective problem solving. Teams are also grounded in the assumption that reliance on others for certain tasks and resources allows collaborators to spend their time doing what each knows and does best (Abramson & Rosenthal, 1995; Bronstein, 2003).

Despite some uncertainty about the contribution of teams to client outcomes and cost effectiveness and the need for more empirical data about team functioning (Abramson & Bronstein, 2013; Faulkner Schofield & Amodeo, 1999), the interdisciplinary team is seen as an integral part of service delivery systems in which social workers practice. As the population of this country expands in its numbers of immigrants, members of racial and ethnic minority groups, and, increasingly, older adults, greater sophistication is called for in service delivery, making the need for the varied perspectives and expertise from different team members vital.

Social workers are in an excellent position to assist teams in addressing the progressively more complex and multifaceted aspects of client care. Social work students learn a variety

of clinical and macro practice concepts and skills that can be easily adapted to work with teams (Hilton, 1995; Kovacs & Bronstein, 1999; Pullen-Sansfaçon & Ward, 2014). These include: careful listening; beginning where the client is; respecting differences; maintaining a nonjudgmental stance; communicating empathically; reaching for feelings; and assessing individuals, groups, and organizations, among others (Abramson, 2002; Dana, 1983; Specht, 1985). Unfortunately, the relevance of these skills for teamwork is inconsistently articulated in the classroom and the practice arena. Social workers often do not recognize or acknowledge that these “clinical” skills are transferable to their work with colleagues, nor do they fully accept that strategic and thoughtful interventions are needed in their collegial interactions (Abramson, 2002).

To draw on these skills successfully, social workers need to relinquish the false dichotomy between the skills they utilize in work with clients and those used when working collaboratively with colleagues. There is little basis for the often-held expectation that professionals can be counted on to “just act professionally.” This assumption does not adequately acknowledge the personal and interprofessional differences that can obstruct teamwork processes. As Fatout and Rose (1995, p. 55) note, “A myth exists that all that is required for effective teamwork is a spirit of cooperation.” Social workers also need to be clear about the importance of applying group work principles to team processes. After all, a team, whatever its primary function, is a group. If the dynamics of such a group are dysfunctional, then its client-focused objectives are less likely to be met. Teams are unique among task groups in the direct connection between their performance and the impact of their decisions on clients. Paradoxically, teams that focus exclusively on discussion of clients’ needs may be ultimately less client-centered than those that also periodically address team interaction issues that have the potential to obstruct the development of better services to clients (Bronstein, 2002; Fatout & Rose, 1995; Mellin et al., 2010).

Once social workers recognize their responsibility to address process issues in teams, they can draw on their group work knowledge base to assist teams in addressing these issues. As stated by Pullen-Sansfaçon and Ward (2014, p. 1284), “Groupwork . . . has the potential, first, to liberate interprofessional teams to function more successfully and hence, second, to deliver better to the service user and, third . . . to contribute to reducing the risks of failure in interprofessional working.” They go on to state, “Social workers, with their values, knowledge and training in groupwork, have potentially a special role to play in facilitating interprofessional teamwork. In turn, this role, if they carry it out well, might help improve their status in the interprofessional team, where currently they often feel marginalised” (p. 1284).

One survey of health care social workers substantiated that, whereas participants in this study expressed comfort with their knowledge of groups, they claimed to need more knowledge and skills to work with teams (Kovacs, Bronstein, & Vega, 2003). This finding suggests that workers are not translating their knowledge of group work to their participation on interdisciplinary teams. This chapter articulates critical issues in team functioning and identifies the key elements of group work practice that are most useful for addressing them.

DEFINITION OF A TEAM

Although the word *team* is used widely, some definitions of teams simply refer to the working together of professionals from different disciplines (sometimes referred to as a multidisciplinary approach). We assume that an effective interdisciplinary team will incorporate the following elements (Abramson, 2002):

- A group of professionals from different disciplines
- A common purpose
- Integration of various professional perspectives in decision making
- Integration of the client and family into team decision-making processes
- Active communication
- Role division based on expertise
- A climate of collaboration

Kagan (1992) describes the concepts of collaboration, coordination, and cooperation as a pyramid, with cooperation at the base, because it is “the most widespread and easiest to achieve” (p. 59). Collaboration, at the apex, is the most complex and difficult to actualize. “Here, joint goals and strategies are agreed on, resources and leadership are shared, and an identifiable durable collaborative structure is established” (p. 60). It is this last, collaborative model of teamwork that we believe is necessary to meet the needs of today’s clients, families, agencies, and communities.

KEY INFLUENCES ON TEAM PROCESSES

Much of the literature on teamwork concentrates on the various obstacles to effective team functioning rather than on strategies to “make teams work” (Abramson, 1989). However, one cannot develop strategies without strong assessment capabilities in recognizing critical obstacles to successful teamwork. Table 27.1 lists commonly encountered obstacles. Many of these problems can be addressed through attention to the group process issues in teams that will be discussed later in this chapter.

TABLE 27.1 Obstacles to Teamwork

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- Continued dominance of higher status professionals
 - Divided or conflicted commitment of participants to the team and to their respective affiliations
 - Role competition or “turf” issues
 - Excessive role blurring or lack of role clarity
 - Differential professional socialization processes
 - Inadequate organizational/administrative support and resources, including limited physical space for team meetings
 - Difficulties resolving conflict
 - Unclear responsibility for team leadership
 - Unskilled team leadership
 - Lack of experience with teamwork
 - Personality difficulties among participants
 - Time constraints
 - Lack of shared professional language and technologies
 - Emphasis on autonomy rather than training for teamwork in professional education
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Note. Based on Abramson (2002), Abramson and Rosenthal (1995), Bronstein (2002), Bronstein and Abramson (2003), Drinka and Streim (1994), Faulkner Schofield and Amodeo (1999), and Lawson and Sailor (2000).

Team Membership

There are few organizing principles for choosing members of a team; most often, the centrality of various professionals to a given client-care task determines the membership of a team. Teams of which physicians are members may deal with the enduring dominance of physicians over team decision making (Abramson & Mizrahi, 1986; Faulkner Schofield & Amodeo, 1999; Freidson, 1970; Mizrahi, 1986; Opie, 2000; Watt, 1985). Some studies have found that when physicians are present, they often take on or are looked to for leadership (Campbell-Heider & Pollack, 1987; Herrman, Trauer, & Warnock, 2002), and their higher status disproportionately influences team interaction, decision making, problem definition, and options for intervention on many teams (Abramson, 1989). Yet their preparation for teamwork is often less than that of other professionals due to the continuing emphasis in medical training on self-reliance and autonomy (Koeske, Koeske, & Mallinger, 1993; Mizrahi, 1986). A different view of the impact of physician status on teamwork is revealed in Emilsson's (2013) work, in which she found that "the majority of the team members (even though some thought they were all equal) suggested that it was the awareness of the obvious hierarchy that implied the mutual collaboration" (p. 130).

Other challenges arise from team composition when the roles of different professions are not clearly defined so that either excessive role blurring or turf conflicts occur (Davidson, 1990; Herrman et al., 2002; Koeske et al., 1993). Although some role blurring is a healthy component of collaboration, there needs to be a balance between role flexibility and strong identification with one's own profession and expertise for teamwork to be most effective (Bronstein, 2003).

A growing body of literature cites the importance of including clients (including youth) and families as core members of teams (Bronstein, 2003; Graham & Barter, 1999; Lawson, 2003; Scheve, Perkins, & Mincemoyer, 2006; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996); yet in practice, if they are involved at all, clients and families primarily participate on a token basis whereby they receive the recommendations of professionals rather than sharing in the decision-making process. Therefore, it is important to recognize that many teams function without collaboration with or substantive input from clients and families, which is antithetical to social work values. Ways to include clients and families as meaningful team members are addressed later.

Impact of Distinct Professional Socialization Processes on Teamwork

The capacity to arrive at consensus in decision making is an underlying premise of teamwork; therefore, it is essential to understand the profound impact of the varied professional socialization processes through which each profession inducts its trainees to its professional worldview (Cowles & Lefkowitz, 1992; Howe, Hyer, Mellor, Lindeman, & Luptak, 2001; Specht, 1985). Professional socialization shapes values, language, preferred roles and models of treatment, patterns of communication, methods of problem solving, and approaches to clients or patients (Bronstein & Abramson, 2003; Mizrahi & Abramson, 1985; Reese & Sontag, 2001; Waugaman, 1994). The process of becoming a professional often involves being mentored or responding to the support of superiors for certain behaviors and attitudes, as well as the formal imparting of professional ethics and knowledge. As an individual becomes a professional, perspectives particular to that profession become so ingrained that awareness of them diminishes; thus they often remain unexamined for their impact on teamwork and collaboration (Abramson, 2002).

Distinctions in professional beliefs and approaches to treatment are often at the root of disagreements among team members. However, the source of such difficulties is often ascribed to the personal qualities of the individual professionals involved, leaving a critical dimension of their collaborative relationship overlooked. Social workers can recognize this dynamic at work if they reflect on their tendencies to react judgmentally when colleagues seem to lack understanding of the client's right to self-determination.

Because professional education inconsistently educates students about the contributions made by other professions or about the tools and perspectives their multidisciplinary colleagues use in their work (Drinka & Streim, 1994; Emilsson, 2013; Julia & Thompson, 1994; Lawson & Sailor, 2000; Waugaman, 1994), we suggest that social workers make concerted efforts to educate themselves about the socialization of other professionals through review of relevant literature and professional codes of ethics beyond their own. Most important, social workers can compensate for the gaps in professional education through systematic, face-to-face discussions with their colleagues in other professions about the factors that have shaped their professional perspectives. See Table 27.2 for a list of questions that can serve as a guide for such discussions.

Clients and their families are also unlikely to understand the norms or socialization of professional team members, and the lack of such knowledge can put them at a considerable disadvantage when attending team meetings. Here, it is incumbent on the social worker to prepare and guide the clients and families as to the professional orientations and roles of the different professionals. The social worker also can assist clients to communicate those aspects of their own culture and socialization that need to be taken into account in decision making; these can include the impact of their neighborhoods, cultures, countries, race, values, religion, and socioeconomic status on their situation and preferences in problem solving.

Communicating the Role of Social Work on Interdisciplinary Teams

Clear articulation of the social work role is a necessary precondition for effective collaboration by social workers with others on the team. Although social work educators do a good job defining social work roles (e.g., Cournoyer, 2014; Hepworth, Rooney, Rooney,

TABLE 27.2. Understanding the Socialization of Other Professions

Questions to ask other professionals

- What is the structure and nature of their training?
- What is the primary focus of their code of ethics?
- What are the values that are most stressed in their training?
- What makes a good doctor, nurse, or occupational therapist, and so forth?
- What is most important to them in taking care of clients (or patients, students, inmates, etc.) or in doing their jobs?
- How do they see their role in relation to clients?
- To what model of treatment do they subscribe?
- What accountability mechanisms are common? What is their relationship to any administrative or supervisory structure?

Note. Based on Abramson (2002).

Strom-Gottfried, & Larsen, 2010), not enough has been done to define how these roles are delineated or described in collaboration with others (Specht, 1985). Studies of nursing and teaching professionals have found that a clear understanding and articulation of one's own role is a critical variable in successful teamwork (McKiel, Lockyer, & Pechivlis, 1988; Mitchell & Scott, 1993). The social work profession still has a distance to go in making clear to the general public and other professionals what social workers "do" (Gibelman, 2005).

Social workers have often contributed to lack of role clarity through their reluctance to accord their resource procurement and advocacy activities equal status with their counseling roles (Abramson & Mizrahi, 1993). Because the prior activities are often those most easily understood and appreciated by clients and other professionals (Cowles & Lefkowitz, 1992), social workers handicap their effectiveness on teams if they do not actively communicate the professional complexities of these activities. They also miss the critical opportunity to portray the uniqueness of social work's capacity to integrate traditional clinical skills with "systems" work, thus providing more integrated services to clients (Abramson, 1993; Mizrahi & Abramson, 1985). Rather than bemoaning the poor understanding by others of their role, social workers need to accept responsibility for active and consistent education of their teammates about their contributions to client care on a case-by-case basis (Abramson, 1993; Abramson & Mizrahi, 1986; Bronstein & Abramson, 2003). Although social workers appear to be doing a better job of this of late—evidenced by Reese's (2011) finding that hospice directors increased their understanding of social workers' roles on hospice teams from 15 years prior—Reese also found that there is still not enough understanding of the social work role by others.

ATTENDING TO GROUP PROCESSES IN TEAMWORK

The team is a group; thus group intervention principles can provide the foundation for addressing group process issues that arise. It is reasonable to assume that any team, however well functioning, will encounter group dynamics that can undermine its effectiveness. Even when things are going well, consciousness of team dynamics will only serve to enhance the team's efficacy. We share the assumption of most teams that their primary function is to focus on those tasks that directly affect delivery of services to clients; such activities are the *raison d'être* for the existence of teams. However, we recognize, as does Shulman (1982), that often, "attention to the process leads directly to work on the task" (p. 221).

Certain tensions are inherent in teamwork and need to be accepted as normative rather than viewed as obstacles. Many of these very tensions contribute to the richness and creativity of the collaborative process, such as the range of professional perspectives or diversity of participants' language, culture, or race (Abramson & Rosenthal, 1995; Kane, 1975; Mizrahi & Rosenthal, 1992). As stated by Pullen-Sansfaçon and Ward (2014):

There are real personal challenges when people move from the comfort zone of the familiar uniprofessional work setting into a maelstrom of new relationships and different professional cultures. However, this is exactly where groupwork, with its focus on interpersonal engagement, can be invaluable. It can offer a platform for connecting members of interprofessional teams, enabling them to recognise the challenges and opportunities of working together and to engage more deeply with the complex issues that many service users face. (p. 1293)

The remainder of this chapter identifies the group work–based intervention strategies and skills that team members and team leaders can draw on to facilitate team functioning.

Monitoring and Assessing Team Processes

Monitoring team processes is a critical team-maintenance task for all team leaders and team members, yet it is a responsibility often taken on reluctantly, if at all. Participants need the capacity to think simultaneously about treatment and team issues so that they are able to address those team process issues that obstruct the client-centered goals of the team. Social workers are well prepared to assess those team dynamics that arise in a particular team meeting, those that are carried over from one team meeting to another, and those that may plague a team for an extended period of time. When working with client groups, they typically attend to interactions among clients while also addressing the topics being discussed; thus they can draw on similar skills in working with teams. Their systems orientation can assist them in evaluating organizational factors that impinge on team functioning, and their skills at tuning in to an atmosphere of tension or lack of productivity can position them to bring such issues to the attention of the team. Such interventions should be encouraged for all team members, but social workers come to teams with the skill repertoire to take on this role. The following example from a prior article (Abramson, 1989) demonstrates such an intervention.

At a team meeting in a rehabilitation hospital, the team leader, who was a physician, mentioned that he would begin interviewing applicants for the position of team psychologist. The former psychologist had been involved in some jurisdictional conflicts with the consulting psychiatrist, the nurse clinician and the social workers. The team leader did not seem to expect any discussion of his announcement and proceeded to review the patient roster for the week. Each team member presented a case for which the intake assessment had been completed. However, the usual exchanges about appropriate treatment approaches did not take place. The leader seemed baffled, asked team members for their opinions several times and then just made the decisions himself.

Finally, one of the occupational therapists commented that everyone sure was quiet today. That remark created more silence. Then one of the social workers said that she didn't know if other people were also preoccupied, but she knew that her mind was on the possibility of a new psychologist and whether the same problems would exist with a new person. When several heads nodded in agreement, she suggested that it might be helpful, either now or later, to discuss the job description for this person. The team leader said he knew there had been some problems, but maybe he wasn't as aware of them as they were. Several people volunteered to meet with him after the meeting to discuss it further. (pp. 49–50)

Contracting with Teams

It is all too rare for teams to have a formal discussion of how the team will operate in relation to membership, attendance, leadership, roles and allocation of responsibilities, decision making, and preferred models of treatment (Kahn, 1974). “The capability to work as part of a team does not emerge without purposeful effort” (Martin, 2013, p. 4). Rather, it is much more the norm for the elements of teamwork to be established by default, by leader preference, or by tradition rather than selected because they make the most sense for a particular team (Abramson, 1989). New members typically “learn the ropes” and become socialized to team norms by observing rather than through any form of direct assistance, such as an

orientation process (Abramson, 1993; Sands, 1989). The discomfort of being an outsider frequently motivates new team members to adopt behavior that will be seen positively by the team (Levi, 2001; Sands, 1989; Werther & Davis, 1985). Thus the opportunity for the team to benefit from the ideas and experiences of new members is often lost. Clients and family members attending team meetings may also hesitate to share their perspectives or advocate for themselves before learning the norms of preexisting teams.

The most obvious time to develop a team contract is at the point of team formation or restructuring, although clarification or modification of the contract can be sought at any time. This contract then provides the baseline against which to measure the progress of the group; members and workers thus use their shared understanding of the contract to identify forces that may obstruct their efforts to accomplish their objectives or that present obstacles to the work at hand (Shulman, 2016).

It is a natural extension to apply contracting concepts used in group work to teamwork. However, concerted effort may be necessary to engage teams in contracting or recontracting processes because so few teams have approached their work in this way. Many of the difficulties faced by teams rest in unexamined assumptions and can be effectively addressed through a well-developed contracting discussion. An abbreviated version of such contracting can occur when new staff members, clients, or family members join the team or when other external forces have an impact on the team's work.

A team that developed individualized education plans (IEPs) for students at an urban elementary school functioned well together for many years in a somewhat static environment. Their unspoken contract for work was based on their assumptions about how to work with the population of students and families who had participated in the school for many years. Over a few years' time, however, individual team members expressed feelings of frustration and a sense that they were not as successful in working with the students and their parents as they had been in prior years. After careful thought, the social worker assessed and found that neighborhood demographic changes over the previous 2 years had created new problems for the team. During that time, an increasing number of immigrants from Haiti had moved into this previously white working-class community, and their children were entering the school.

Team members had been feeling ineffective and were relieved when the social worker suggested that a new contract for work needed to be established, one that was based on the needs and strengths of the new population of students and families. The worker agreed to locate reading materials on Haitian culture to share with team members in helping to craft such a contract. She also agreed to plan a forum for dialogue with immigrant parents at a faculty meeting about the different educational expectations for students *and* parents in Haiti and in the United States. This new information then became the basis for a team contract regarding expectations and roles for professionals and families in the future IEP meetings.

Creating a Climate of Openness, Trust, and Group Cohesion

Group cohesion is difficult to describe, but most team participants would swear that they "know it when they experience it." Although team cohesion is generated from a number of sources, team members primarily experience it in an affective way, as a sense of belonging and ownership of the team's processes and outcomes (Keyton, 2000). Fleming and Mond-Amaya (2001) note that experiencing trust and respect for other team members, as well as

comfort in sharing ideas, contributes to team cohesion. Cohesion and synergy among team members have been identified as contributing to commitment to the team (Barrick, Stewart, Neubert, & Mount, 1998) and to its effectiveness (Fleming & Monda-Amaya, 2001; Martin, 2013). Highly collaborative teamwork styles, greater role clarity, and acceptance of team goals, values, and norms of performance also enhance commitment to the team (Lewandowski & GlenMaye, 2002; Nandan, 1997). These variables significantly affect satisfaction with the team as well, with respect for colleagues having a major impact on satisfaction (Abramson & Mizrahi, 1996; Bronstein, 2002; Lewandowski & GlenMaye, 2002).

A social worker wishing to facilitate the development of greater team cohesion would do well to focus on promoting mutual aid processes within the team. Team members clearly need each other to accomplish their assigned responsibilities, and thus they are engaged in a mutual-aid process. Some key aspects of mutual aid likely to play out in team interactions include mutual support, a mutual demand or expectation to accomplish the work of the group, sharing data, the development of the “all-in-the-same-boat” and “strength in numbers” phenomena, discussion of taboo areas, and joint problem solving (Bronstein & Kelly, 1998; Shulman, 2016).

Mutual support occurs when team members are “there” for one another as they deal with challenging patient/client circumstances and with the disappointments and struggles that are part of their daily work lives (Bronstein & Kelly, 1998). Such support provides the cushion that then allows team participants to assert their expectations of each other or make a “demand for work” (Schwartz, 1961). That same sense of support also makes the discussion of more taboo or painful topics possible (Shulman, 2016), and the sense of “strength in-numbers” and that we are “all in the same boat” can encourage both staff and client/family team members to take on challenging or intimidating issues and tasks (Bronstein & Kelly, 1998).

Other strategies also increase trust and create a climate of openness. “Trust building is often closely intertwined with interpersonal relationships, interaction and team-building processes” (Emilsson, 2013, p. 131). Some of these strategies are most effective when the team leader initiates them, as the leader often has disproportionate influence on the development of team culture and norms. For example, the leader can mediate the tendency in many teams for higher status professionals to dominate decision making by promoting participation by others and supporting their contributions. At times, the leader may need to directly question an assumption or mode of operating of a higher status member whom others are hesitant to confront (Abramson, 1989). Team leaders can promote a sense of identification with the whole team, even in the face of seemingly contradictory professional ideologies and loyalties; however, to accomplish this, leaders must demonstrate evenhandedness in territorial disputes and must be careful not to overidentify with or overprotect members of their own profession. Finally, leaders can offer an optimistic vision of the team’s potential for problem solving and working effectively together; communicating such a perspective evokes the energy, motivation, and capacity needed for successful teamwork (Abramson & Rosenthal, 1995).

Team members also can contribute to team cohesiveness and an atmosphere of respect and trust by modeling positive team behavior, even when a team leader has not created such norms. Support for others who take risks can be critical, as can building on or supporting another member’s ideas. If a team member evaluates the idea of another member on its merit, without regard for the status or personal appeal of the individual or for his or her subgroup affiliations, others are more likely to do the same (Fisher & Ury, 1983).

Dealing with Conflict

Teams that can successfully manage conflict find their cohesion as a group greatly enhanced by their capacity to deal with differing points of view. The development of consensus in decision making and growth in team functioning often depends on the ability of group members to confront conflict within the group directly (Martin, 2013; Northen, 1988). The inability to deal with conflict within the team is perhaps the most critical obstacle to effective collaboration (Sands, Stafford, & McClelland, 1990). The following factors are likely to produce conflict (Abramson & Rosenthal, 1995):

- The participants have a history of adversarial relationships.
- The team includes ideologically diverse participants or those with different professional or organizational cultures.
- The outcome has the potential to shift dominance from those in power.
- The participants hold differing interests regarding the desired outcome.

Although individual team members and leaders encounter many difficulties in addressing conflict in teams, numerous “tried and tested” approaches exist that teams can draw on to manage conflicts. For example, efforts by “opposing” team members to recognize and understand the varied investments of stakeholders in a particular perspective can provide a foundation for “getting in others’ shoes.” Such assessment is the first step toward developing strategies to resolve conflict. Because these strategies are grounded in both an intellectual and an empathic understanding of another’s perspective, there is greater likelihood that they will be effective. Most professionals are familiar with listening skills and apply them successfully when working with clients; however, once again, they often do not apply such skills with their colleagues nor recognize the potency of this approach for collaborative interactions. It is possible that the presence of clients and family members in team meetings may help to evoke the listening skills that most professionals possess.

Helping team members to acknowledge a conflict and express the reasoning behind conflicting opinions and alternatives can be a significant first step. When positions harden, it is useful to develop jointly agreed-on decision criteria or to identify the acceptable and unacceptable parts of each alternative; then it is often possible to combine the acceptable parts of several alternatives into one solution (Toseland & Rivas, 2011). Because resolving conflict inevitably involves some redistribution of power, it is important to avoid a total win-or-lose situation (Gouran, 1982). Common ground can be sought through reframing a contending perspective in terms of others’ needs, ideology, or language. For example, a social worker interested in obtaining service for a client might stress the potential for learning from a specific case when presenting it at an intake meeting in a training setting (Abramson, 1989).

Much dissension or disagreement is expressed indirectly in team meetings through inattention, exchanges of glances, loss of eye contact, evidence of irritation or frustration in tone of voice, subgroup talking, sub-rosa or sarcastic remarks, eye rolling, and even physical restlessness. It is essential to address these indirect communications of conflict (see Table 27.3 for conflict resolution strategies). Such behavior should stimulate other participants to seek out the underlying meaning. It is more effective to bring the behavior to the attention of the team through humor or use of one’s own feelings rather than “accusing” others; in this way, defensiveness can be avoided, and others will be more likely to engage in an exploratory process (Abramson, 1989).

TABLE 27.3. Consensus-Building and Conflict-Resolution Strategies for Teams

-
- Emphasize points of consensus and broad, unifying themes.
 - Deal with safer issues initially.
 - Partialize conflicts into manageable parts and into areas in which there is common ground.
 - Combine the acceptable and unacceptable aspects of each alternative into solution.
 - Use decision criteria jointly agreed on.
 - Gain consensus incrementally—a piece at a time.
 - Reframe issues in terms of others' language or ideology.
 - Demonstrate support and respect for differences—build culture in which difference is tolerated.
 - Avoid self-righteousness.
 - Separate the person from the issue.
 - Emphasize unifying themes.
 - Reach for indirect expression of difference.
 - Don't paper over underlying but deeply felt disagreement.
 - Recognize impact of socialization differences; develop strategies more relevant to those kinds of differences.
 - Maintain a professional demeanor.
 - Avoid a total win-or-lose situation.
 - View conflict as a normal and helpful part of teamwork.
-

Note. Based on Abramson (1989, 2002), Graham and Barter (1999), and Toseland and Rivas (2001).

Developing Client-Centered Norms

At times, teams develop a culture or set of norms that can have a negative impact on clients and families. Teams that deal with client problems that are complex, overwhelming, and not easily addressed may find themselves using humor inappropriately or blaming clients as ways to deal with their own frustrations (Fox, 1980). Teams and team members may lose the capacity to individualize certain categories of clients, especially those with poor prognoses, those described as manipulative, or those for whom available interventions do not easily succeed (e.g., often called “resistant”). Such behavior may be less apt to occur overtly when clients and family members routinely participate in teams; however, it still may occur in informal or formal team discussions when they are not present or in subtle or nonverbal form when they are.

An alert team leader needs to identify such patterns and call the members' attention to them; an individual member also can raise such issues with other members and/or the team leader so that support is generated for addressing the problem. It can be helpful to use a retreat format, away from the pressures of client care, to reflect on the dynamics and resolution of the problem. The following example from a prior article (Abramson, 1989) illustrates such a situation.

Team members in an outpatient clinic for substance abusers had begun to set very limited treatment objectives for low-income clients. The team leader assessed this response as relating to a disproportionate number of treatment failures with this group of clients. She observed team members gradually withdrawing from this population and decided to raise the issue at the team meeting. After evoking much frustrated commentary from the team members, she suggested bringing in a consultant, followed by brainstorming sessions to integrate the consultant's input with the extensive knowledge already available within the team. (Abramson, 1989, p. 55)

Integrating Clients and Families into Teams

Although the inclusion of clients and families in teams has been discussed throughout this chapter, it is a complex process that deserves further discussion. Clients and families present their own unique sets of challenges to team functioning, yet their involvement also opens up an array of possibilities that would not exist without their participation. Two major challenges that result from including clients and families as core team members include their time-limited involvement and their perceived power deficit.

Even though team membership is often somewhat fluid, the time-limited involvement of the many clients and their families whose needs the team addresses raises particular issues. However, as professional team members work together over time, they can develop ways to best greet, guide, and welcome the input of clients and families into their care planning. Strategies for incorporating clients and families successfully into teams include (1) preparing clients and families for team participation, (2) jointly developing meeting agendas, (3) limiting the number of professionals present, (4) avoiding technical language, and (5) keeping client/family concerns central (Opie, 2000). Social workers have revealed that more productive team interactions and outcomes have occurred when clients and families participate in all stages of decision making (Bronstein, 2002, 2003).

The challenges inherent in the power differentials among team members were noted earlier; inclusion of clients and families in the team makeup can further complicate the team's power dynamics due to their status as recipients rather than providers of service. Social workers can help to empower clients and families such that their involvement goes beyond token status to actually holding teams accountable for providing the best possible care plan available. In some circumstances, clients and family members may be better able to challenge higher status professionals (i.e., physicians) than are social workers, nurses, and other professional "colleagues." In order to have an interprofessional team that truly serves clients' best interests, clients and their self-defined family members need to be integral team members. Achievement of such an objective requires team members to value the input of clients and families as critical to the entire process of design, definition, development, and attainment of goals. Active participation by clients and families in teams can begin to make inroads into correcting the enormous imbalance of power between them and the professionals who so often make decisions of great consequence for their lives.

Future Directions in Teamwork

Research

Until this point, we have examined those factors likely to affect team processes and have identified the group work strategies most likely to improve team functioning. Given that teams are the primary mechanism for service delivery in many settings, enhancing their

effectiveness can only better serve clients and families. However, research on the work of interdisciplinary teams and what makes them effective needs to be expanded. Much clinical wisdom and many case studies exist, and there are beginning to be outcome studies to guide this work, but there is a serious lack of evidence-based models to define and guide best practices. A number of instruments exist in social work and related fields to assess teamwork, but these instruments rely largely on selfreport (e.g., in social work, Bronstein, 2002; in nursing, Joy & Malay, 1992; in early childhood education, Garland, Frank, Buck, & Seklemian, 1995; in organizational research, Kivimaki, Kuk, Elovainio, & Thomson, 1997, and Watson, Johnson, & Merritt, 1998; in school mental health, Mellin et al., 2010; and in intensive care, Weller et al., 2013). Specific areas cited in the literature as influences on teamwork should be empirically examined for their impact on team processes and outcomes—differential professional socialization, structural and organizational dimensions, contracting processes, the balance between task and process emphasis in teams, conflict management strategies, personal characteristics, and so forth (Bronstein & Abramson, 2003).

Further studies also need to employ a broader range of research methods and of topics. Methods can include longitudinal studies that look at teams and their outcomes over time (Phillippo & Stone, 2006; Salas, Sims, & Burke, 2005) and social network analysis (SNA) to assess relationships among team members and their relationships outside the team. Cost-effectiveness data should be examined to determine empirically whether and how the time taken through teamwork yields outcomes that warrant the use of multiple professionals' time (Ernst & Smith, 2012). Social workers in both practice and academia can add to the knowledge about teams with case studies, models, and research that focuses specifically on dynamics that occur when clients and families are integral team members; as diversity increases among professional, family, and client team members, the impact of this factor on team processes and outcomes will need to be examined as well.

Social Work Education

In addition to further research efforts, social work educators can make more explicit linkages between students' knowledge of group work and their work on interdisciplinary teams. This content should be required in foundation-level micro and macro practice courses, as well as in concentration-level courses in group work practice or interdisciplinary settings. Assignments in these courses can focus on collaborative as well as clinical work. Outside the classroom, field instructors can also foster this linkage in their supervision of students in the field. For example, field instructors can require that students produce process recordings of team meetings. If this aspect of their practice is elevated in importance to that given direct work with clients, and if students are evaluated on their performance in collaborative arenas, they will be eager to learn teamwork and collaborative skills. Field instructors will also need to articulate and consistently reinforce the connections between the group work skills that students are using in their clinical work and the skills they will need as team members.

Over the last decade, numbers and types of social work education courses and programs have been developed in an array of countries, including the United States, that support knowledge for working in teams and across disciplinary and professional boundaries. Many of these focus on different interprofessional/interdisciplinary partnerships (Bronstein, Mizrahi, Korazim-Körösy & McPhee, 2010; Hutchinson & Korazim-Körösy, 2015), such as those in which social work students collaborate with students studying law (e.g., Burry et al., 2011; Hyams, Brown, & Foster, 2013), engineering (e.g., Gilbert, 2014), medicine (e.g.,

Salas et al., 2005), nutrition, nursing, medicine, and public health (e.g., Lennon-Dearing, Florence, Garrett, Click, & Abercrombie, 2008), physical therapy (e.g., Rowan et al., 2009), physics (e.g., Lee, Anderson, & Bronstein, 2015), and architecture (e.g., O'Connor, 2007).

Types of Collaboration Relevant for Teams

Last, it is critical to keep in mind that interdisciplinary or interprofessional teamwork is only one “type” of collaboration; it is not exercised in a void and is best achieved when interlocking with a number of other “types” of collaboration. Payne (2000, p. 3) argues, “teams cannot just be about interpersonal group relations among professionals working together”; they “must also be a center of relationships within wider multi-professional, service user and community networks.” These other forms of collaboration require the same skills necessary for interprofessional teamwork (Payne, 2000). Lawson (2003) categorizes these collaborative types as intraorganizational, interorganizational or interagency, and community based, among others.

Intraorganizational collaboration speaks to relationships within the same organization that stretch beyond the interprofessional team. This kind of collaboration is fostered in agencies in which professional and nonprofessional staff members share and feel empowered to support the agency mission. Intraorganizational collaboration occurs, for example, when a school bus driver, who is not a formal team participant, speaks to a teacher about something significant he or she has heard from a child on his or her bus. It is fostered when secretarial staff members at a mental health clinic, who are not usually part of the team, are included with professional staff in an inservice training session about ways to handle clients exhibiting upsetting behaviors in the waiting room. Collaboration that extends beyond the team lays a foundation for the advancement of team goals and processes by informally incorporating the contributions of other agency workers.

Interorganizational or interagency collaboration, often referred to as services integration, attempts to secure genuine engagement, shared responsibility and accountability, and coproduction capacities among two or more organizations (Lawson, 2003). These collaborations are most successful when agency relationships, policies, and practices are formalized into clearly articulated agreements that go beyond what occurs when representatives of two or more agencies meet to plan for a particular client. For example, when hospitals have interagency agreements with community agencies, attendance of staff members from these agencies at team meetings to plan patient discharges can facilitate more seamless transitions for patients. In addition, such interagency relationships can extend the team’s impact through the building of coalitions to address service gaps and local, state, or even national legislative and policy advocacy.

Community collaboration involves soliciting input, investment, and participation from lesser heard residents and service providers about local needs and initiatives. This involvement can enhance the interdisciplinary team in its work by providing resources and information not otherwise available. A wide consumer base can be garnered through community collaboration, which can broaden team goals and also provide support to the team in developing and advocating for a policy agenda that is truly grounded in community needs.

In addition to these kinds of collaboration, Lawson (2003) identifies other, larger system levels as important in supporting successful collaborations for the interprofessional team. These include intragovernmental collaboration, intergovernmental collaboration, and international collaboration. The connections between these types of collaboration and teams need further exploration; however, it is safe to assume that governmental and global

factors will have ever-increasing impact on services to clients and thus on the teams trying to provide care.

CONCLUSION

The purpose of this chapter has been to discuss the application of group work knowledge and skills to productive teamwork. However, this application cannot occur in a vacuum. It cannot be fostered without the assistance of researchers who build knowledge about productive teamwork processes or without social work educators who pass this knowledge on to students or field instructors who teach teamwork skills to students. And team processes cannot develop effectively without the contextual supports and other “types” of collaboration necessary to build and pave the road on which teams need to walk in their journey to serve clients. We count on teams to be a primary mechanism for service delivery, yet we do not provide enough of the conceptual and skill-building supports necessary to do the job we expect of them. Here we suggest that some of the resources needed are available to social workers through their understanding of group processes and interventions with groups. We encourage teams to attend to their internal processes in the belief that such attention can make a significant contribution to improved team morale and functioning and to better outcomes for clients and families.

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CHAPTER 28

Group Work with Working Groups

PAUL H. EPHROSS
THOMAS V. VASSIL
STEVEN R. ROSE

This chapter discusses group work with working groups, those formed to develop a product or outcome external to the group itself. These groups seek to fulfill a specific function for the organization, community, or social movement of which they are part or which they represent. Others have used such terms as *task groups*, *administrative groups*, *staff and administrative groups*, *groups for indirect services*, *groups in organizations*, and *citizens' groups* to distinguish such groups from those whose primary purpose is to bring about change in the members themselves through the processes of group treatment or group therapy or through psychoeducational experiences (Ephross & Vassil, 2005).

The term *working groups* can be controversial. Treatment groups, those formed to heal their members, also regard themselves as “working” in the sense that the group is addressing its therapeutics. Others point out that certain phenomena are characteristic of all groups, regardless of their purpose (Hartford, 1972; Henry, 1992). Henry notes, however, that

groups are an appropriate form for offering service to people with personal needs that are socially oriented. There are other kinds of needs, however, for which groups are an appropriate form of service. These are needs outside a person's individual needs, ones that can be met in some formal organization: boards, committees, and task-action groups for task accomplishment; agency in-service training, supervision and staff development groups for role performance; and consultation groups with decision and policy makers, with administrators, with direct service providers or with interdisciplinary teams for improving the functioning of an organization. (1992, pp. 248–249)

In task-specific groups, work is defined by specific problem-solving activities that may range from creative to mundane (Thelen, 1958). These activities are meant to bring about change either in systems external to the group or in an organization or community of which

the group is a part. Conscious of its limitations, we choose the term *working groups* as the most inclusive.

Examples of working groups are:

- *Staff groups*: the staff employed by human service and health care organizations, paid and volunteer, composed of social workers or organized into multiprofessional teams.
- *Administrative groups within larger organizations*: committees or task forces charged to carry out a job or to provide a particular product for the entire organization or groups established and charged with responsibilities by statute or ordinance; often these are interagency bodies that prepare a budget proposal or review and evaluate the performance of an organization or investigate accusations of malfeasance.
- *Fiduciary groups such as boards of directors, electors, governors, or trustees*: whether established by law, in the case of a governmental organization or corporation, or through bylaws, as in the instance of a voluntary not-for-profit or for-profit service delivery organization.
- *Well-established or ad hoc citizens' organizations*: may involve citizens of a particular polity or residents of a neighborhood; members of one or many religious congregations or denominations or religious faiths; or persons representing one or many ethnic or racial groups or nationalities who are seeking help from a social worker who has the executive ability and skill to help them accomplish their purposes.
- *Groups defined by their own needs for a particular interest or activity*: for example, mothers or fathers of small children seeking to expand day care opportunities in their community.
- *Groups within advocacy organizations that represent and seek to advance the interests of particular populations*: these may be themselves or others, including those defined by race, sex, religion, national origin, physical disability, and age.
- *Groups within professional and multiprofessional organizations*: the former to advocate for the interests of the social work or other profession of which it is part, the latter generally concerned with a specific social or health problem—such as meeting the needs of young people with juvenile diabetes or the nutritional needs of older people or the job training needs of recent immigrants; revising the procedures through which children are assigned to foster homes is another example, as are groups within labor unions and coalitions of various unions.
- *Groups composed of organization representatives*: staffing such groups is often a responsibility of social workers employed by federations or associations of agencies, by the United Way, or by various other kinds of councils of agencies or fundraising and allocation agencies or even representatives of treatment agencies that serve the same local or metropolitan community.

One of the members of working groups has a specialized role—namely, carrying executive responsibility for serving the needs of the group and helping the group implement its decisions. That person is charged with representing and working on behalf of the group as a whole—in many instances with working to achieve the purposes of the larger organization or community—and is generally paid for fulfilling the professional role, though volunteers are not unknown in this role. We prefer the term *staff person* to identify this individual to the term *worker*, as the latter term has little currency outside the profession of social work.

WHAT IS DIFFERENT ABOUT WORKING GROUPS?

Social workers can participate in working groups as members, can staff them, and can serve as their chairpersons. They can also serve as members and chairpersons of subunits such as committees, subcommittees, and task forces. Much of the work of the social work profession is conducted in working groups. Thus group workers need skill not only in staffing but also in taking the roles of member and chairperson in working groups (Balgopal & Vassil, 1983; Bertcher, 1994; Henry, 1992; Toseland & Rivas, 2012).

Staffing working groups has long been a part of social work. The profession grew out of volunteer organizations, stimulated in part by the emergence of the Social Gospel movement in the various mainline Protestant denominations in the late 19th century and in part by the efforts of immigrant Catholics, Jews, and others to learn the English language and the skills to become Americans (Ephross & Vassil, 2005; Hartford, 1964; Siporin, 1986). In the early history of social work, much of this staffing responsibility fell to the chief staff member, variously known, over time and different organizations, as the general secretary, the executive secretary, the executive director, and now often as the chief executive officer (CEO) or the president, in imitation of business nomenclature. In the past, many social workers devoted to direct practice have shown a lack of interest in working with boards, committees, and community groups. An exception to this trend was, and still is, to be found in the settlement house–neighborhood center movement (Trattner, 1989). Staff members of these agencies have always understood the importance of working closely together with neighborhood and community groups.

Many group work textbooks devote one or two chapters to working groups (e.g., Brown, 1991; Garvin, 1997; Toseland & Rivas, 2012), whereas others (e.g., Northen & Kurland, 2001) view work with all groups through a common set of lenses, with only occasional references to working groups. Community organizers and administrators, both of whom work extensively with working groups, largely gloss over the question of group work skill. Three exceptions to this general comment should be noted. The first is an aging but still vital book by Steve Burghardt (1983), in which he devotes a major chapter to an account of the importance of working group skills for community organizers and the personal stresses and issues raised by community organization practice, especially in working with and in working groups. A second is the work of John Tropman (1987, 2014), whose writings emphasize the importance of skilled planning by the staff person in helping working groups accomplish their purposes. Tropman teaches the need to balance helping group members to meet their participatory needs with helping the groups of which they are part to accomplish their goals. A third exception is a chapter titled “Group Work in Context: Organizational and Community Factors” by Elizabeth A. Mulroy (2004), in which she relates the external turmoil of contemporary American economic and social contexts to the internal processes of groups within service delivery organizations.

Small groups can be viewed as the decision makers and framers of organizations (Lincoln, 1989). Small groups are incubators of organizational cultures, which, in turn, affect volunteers, staff members, and clients of service delivery organizations. It is in working group leadership and membership that careers are forged, maintained, or left to wither.

A cautionary note is in order. Not all collectivities or aggregations, whether inside or outside organizations, deserve to be called groups. There are many group-like collectivities that may look like functioning groups. However, their lack of adequate completion of the processes of group formation and development precludes them from being full-fledged groups. The structures first taught by Coyle and refined by the various useful and helpful

stage/phase models from social work and related fields as to what is and what is not a group need to be borne in mind (Coyle, 1937, 1947, 1948; Garland, Jones, & Kolodny, 1965; Hartford, 1972; Sarri & Galinsky, 1985; Schiller, 1995; Schwartz, 1976; Tuckman, 1965; Tuckman & Jensen, 1977). Research into working groups and social work in working groups needs to come from studies “in the wild,” studies of actual groups in their organizations and communities, what Frey (2001) has called “bona fide groups.”

WORKING GROUPS AS DEMOCRATIC MICROCOSMS

Erich Fromm (1941), then a refugee from a brutal dictatorship that destroyed the lives of millions of people, argued that a human need exists to escape from freedom. What, after all, is so bad about an effective, humane dictatorship in a group? In our views and experience, it prevents a group from forming as a democratic microcosm, keeps its members and its leadership from assuming responsibility for themselves and their work, and, in the end, prevents a group from being effective. It also funnels communication with the outside world through autocratic leadership figures, rather than promoting the development of open-system mechanisms for feedback from the other parts of the ecological system of which the working group is a part. Participatory democracy, within laws and a structure of rules, checks, and balances, is a requirement for group productivity. Modeling, teaching, and insisting on participatory democracy is a prime function of the professional social worker in groups.

Civility and authority are prime requirements for democratic group function (Ephross & Vassil, 2005). Fear, threats of retribution, violence directed at members, their group, and organization, or the threat of violence, scapegoating, or persecution are not part of democratic working groups. Helping to prevent the formation of a group culture based either on chaos and a lack of equanimity and civility or on interpersonal domination, fear, and scapegoating is a prime responsibility of the professional staff person in a group. Shulman (2001) suggested that preemptive intervention is the proper way to deal with a scapegoating process, whereas Northen and Kurland (2001) pointed out that the role of scapegoat in a group is an interactional role, not a one-way process imposed on one or more group members.

The staff person's role is to declare scapegoating unacceptable if the group is unable to get across this message by itself. Approaches need to be clear and based on the realities of the group's purpose. For example, statements such as, “We don't do that here,” “This is not what we're here for,” or “How will this help us get done what we need to?” can help a staff person to begin or end such a process.

The same may be said about discrimination and hate speech directed at members of those within or outside the group or organization because of their identities and social or demographic characteristics, including race, sex, religion, national origin, physical disability, and age. As much as civility and safety are requirements for working groups, so is the perspective that differences among members enrich groups and give their decision making and consideration of issues an invaluable vitality and relevance to the social world outside the group. Authentic communication and honest disagreement are valuable to working groups, and freedom of speech deserves protection. Combatting intergroup hatreds is a worthy activity. In regard to what is deemed to be acceptable communication and activity, staff persons and members need to decide where the line is in each specific instance.

Working groups are systems in mutual aid with a common purpose, tasks to perform, and often products to develop (Steinberg, 2004). If accomplishment of their tasks requires a mature working group, it is important for the organization of which the group is a part, the

staff person, and the members to make the investment of time and energy that helping such a group develop requires. A working group that is moving toward becoming a democratic microcosm and a system in mutual aid should be “our” group. It is never “their” group or “your” group. By these labels, we mean that each member of the group carries some responsibility for the totality of the group’s functioning. Everything the group does is the business of every member. All suggestions should be welcomed, even those that cause problems for the group’s leadership, because they represent an expression of concern and an input of energy from the member or subgroup offering the suggestions (Ephross & Vassil, 2005).

The concept of mutual aid has important implications for the professional role behavior of the staff member. Finding good in what members contribute is better than criticism and rejection; and the phrase “conscious use of self,” so easy to say and often so difficult to enforce, is a prescription for a professional’s behavior that is as old as group work itself. It is better to be real than to try to be perfect, for genuineness and authenticity on the part of a staff person invite trust, friendship, and participation, whereas presenting oneself as perfect both discourages trust and is doomed to fail.

A FRAMEWORK FOR UNDERSTANDING WORKING GROUPS

Many concepts provide a framework for understanding what goes on in working groups and guide group workers’ participation and influence in such groups. We only list and briefly comment on some of these concepts. The reader is referred to fuller discussions elsewhere (for contracting, Shulman, 2001; for the others, Ephross & Vassil, 2005). These processes include the following.

1. *Contracting is especially important in working groups because, with few exceptions, members of such groups are there either as part of their work responsibilities or as part of their voluntary behavior as citizens.* In either case, it is important that there be agreement as to why they are there, what the purposes of the working group are, what roles members will have, what risks, if any, come with membership in the group, and who has the ability and authority to decide on changes in the contract (McDermott, 2002). All group contracts are subject to renegotiation by the group in the course of its life, and part of the contract should specify who is responsible for implementing group decisions. The purposes of the working group are usually transformed into goals and objectives.

2. *Working groups aim to solve problems and must make decisions to do so.* Indeed, decision making is an important component of the problem-solving process. The latter is one of many processes that take place in the working group.

3. *Duration of the group is a significant consideration.* Some working groups are ongoing or open-ended, and others are time limited. Short-term and long-term groups form and operate at different paces (Steinberg, 2004). An awareness of the available time frame seems to seep into working groups. A group that has a total of only four or five meetings to prepare an organizational budget that is due in the state capitol in 6 weeks will tailor its use of time, its discussions, and its decision-making process so as to fit within the time available. The length of a group’s life also has an effect, in our view, on the investment that members are willing to make in the group. One is likely to feel more committed when one undertakes a 3-year term on a board of directors, for example, than when one agrees to attend two meetings of a focus group. Another factor to consider about the length of a group’s life is who

makes the decision about how long a group will last. Frequently, the working group makes the decision. Sometimes, though, this is not a decision that falls into the working group's purview. Bernstein (1993), who was concerned with group self-determination throughout his long career, asked, "Whatever happened to self-determination?" Like individuals and families, groups feel a sense of empowerment when they are able to control important aspects of their own lives and a sense of disempowerment when they are not (Manor, 2000).

4. *The public and private sentiments of members have an important and ongoing impact on working groups.* Only a part of group members' feelings, and therefore of their interactions with each other, lies above consciousness. This is to be expected and needs to be understood by other members, by the chairperson if one exists, and by the staff person as well. We select two examples from among many possibilities. Diversity of identity within a group and between group members and staff person are often present in working groups. Members may be concerned with impressing other members for a variety of reasons. Interpersonal histories and loyalties, as well as past group experiences, may play a part. It is not unusual, for example, for community groups, as well as staffs, to contain two or more people who are related to each other. Not all of the private feelings that one member has toward another can be, or even should be, brought into the open or become topics for the entire group. Sentiments derived from past experiences exist in the working group. Although the direction that they take and their history is sometimes a surprise, they are to be expected by the staff person.

5. *The nature of interpersonal bonding is often different in working groups than in other types of groups.* The relationships formed may be quite intense as long as the group is working on a project dear to the hearts of some group members, but they may also be task specific and time limited. When they are not, issues of ethics and boundaries may be raised and need to be dealt with by the members involved or by the group as a whole, with or without the help of the staff person. For example, working together on a committee or subcommittee or coming to a meeting of such a body at someone's house may indicate to some group members an invitation to intimacy that is far from the intention of the subcommittee chair or the host or hostess.

Borrowing from the language of chemistry, we refer to interpersonal bonds in groups as "simple" when the exchange between people is largely or entirely informational. We label as "covalent" an interpersonal bond that is meaningful to two or more group members. We have in mind a situation akin to what writers from Schwartz (1976) to Northen and Kurland (2001) have termed "mutual aid" experiences. The latter authors write movingly about the difficulty that some group members have with accepting termination (pp. 420–421), and their observations apply to some members' experiences in working groups, as well as to members of other kinds of groups.

Some interpersonal relationship experiences in working groups can truly be called transformative for the members involved or sometimes for the entire group. We use the label *coordinate covalent* for such relationships, which may affect a change of roles within the group or in many areas of group members' lives far removed from the particular group (Argyris & Schon, 1974). We recall a good many such relationship experiences in groups, ranging from a settlement house board of directors to a technical advisory committee for a demographic study of a community's population. For many people, experiences in working groups can trigger important changes in class-linked perceptions and attitudes. Though such experiences are not stated goals of working groups, in the vast majority of cases, they are important and deserve empathic support from social work staff.

6. *Molar–molecular characteristics, another borrowing of terminology from the field of chemistry, are often important in groups.* These are part–whole relationships, as among subgroups—for example, between those who live east of the tracks and those who live to the west; between long-standing residents and newcomers to the neighborhood; between the men who once held all of the places on the board of governors and the women who now make up half of the board. One place in which molar–molecular dynamics can often be seen is in councils, which are groups made up of representatives from other groups, or in coalitions that have gotten together because they share positions on a particular issue, though they and their memberships may differ widely on many other issues. An example may be a statewide coalition that includes many persons from faith-based organizations that seeks to act on behalf of the needs of the state’s children. That no child should go without medical care or enough food to eat may seem to be the only two things on which everyone on the steering committee of this coalition agrees.

Several of the aforementioned areas raise an issue for practice that causes a common conflict for staff persons. This conflict is often stated as *process* and (or versus) *product*. No matter how interesting and how rich in social importance, nor how engaging the discussion is for the staff member, at some point one must seek to limit the discussion because some important votes are needed on the budget, which is due in the state capitol next Tuesday. Despite the fact that tension exists among several subgroups, can the group progress toward its goal? Or should the staff person influence the group to stop working on its product and engage in a bit of self-analytic introspection to try to clear the air, as well as the members’ minds? The specific answers to such questions also depend largely on the indigenous leadership of a specific group.

7. *Developmental stages of groups are crucial elements in most groups at one time or another.* Though stages of group development is a helpful concept, it must be kept in mind that stages are abstract ideas, whereas group members are persons who live and breathe, progress and regress, express their feelings or submerge them, and sometimes regret whichever path they take. Frequently, working groups do not progress in a straight line. Also, even though group members may be meeting the staff person for the first time, various dyads, triads, and larger subgroups may have known each other for a long time, may have worked together in other groups, may have gone to the same schools or colleges or worked together on the same political campaigns, or may belong to the same civic and social organizations. A first meeting may be a first meeting in fact or may be a reunion for everyone in the room except the staff person.

8. *Learning takes place in working groups.* Whether or not the working group is educational, didactic, or devoted to training, it should be conducive to learning by the leader, members, or the group as a whole. Such learning may be social in nature, or it can involve the acquisition of knowledge or skills.

9. *The organizational setting is a vital dimension in many working groups.* Most working groups take place in an intra- or interorganizational context that influences the work of the group. What varies greatly is the loyalty that group members bring to the working group. Some are loyal to the organization overall, some to a specific part or branch or department, some to their own careers in the organization. Some members draw their personal authority and influence from “local” sources, that is, from sources within the particular organization that sponsors the group; others from “cosmopolitan” sources, that is, their broad experience in many organizations or in the world outside of the particular organization’s emphasis (Wilson, 1985). For some members, their technical skill is the important

link to the working group; for others, pleasure and/or gain exists in being associated with the other people in the group. For some group members, the working group may be a step up from the point of view of social mobility, either within the organization or in the broader communities. For example, there may be a traditional family tie to certain boards or commissions or to public service in general, a sort of *noblesse oblige*, which spans generations and is a marker of community social status.

10. *Group composition, group membership and citizenship, and the makeup of the group as a whole are characteristics that are always present, always important, and always foci of growth or decay.* They constitute an important part, though not all, of course, of the identity of the group and therefore of its life. It is partly for this reason that the ability to hear, not just in the auditory sense but in the sense of communication, and to understand others in depth, which is correctly understood as a clinical social work skill, is also an important skill for members, leaders, and staff persons of working groups. In our view, participating in, leading, and staffing working groups demand finely honed skills that are essentially the same as those required for group work with other kinds of groups. Northen and Kurland (2001) quote approvingly Newstetter's definition of group work at the 1935 National Conference of Social Work, the conference at which group work was formally inducted into the social work profession:

All group work has a dual set of objectives, working for social justice and working to meet the needs of the group members. The balance or proportion of effort that needs to be devoted to each of the purposes is what differentiates social work with working groups from social work with other kinds of groups. (Newstetter, 1935, quoted in Northen & Kurland, 2001, p. 9)

11. *Working groups are often the foci of conflict.* The leader can harness such conflict between members or subgroups such that it is resolved or used to energize the group. An additional source of energy for the group is the motivation of the members to participate. It is the leader's task to enhance such motivation.

LEADERSHIP IN WORKING GROUPS

In a working group, leadership is vital and complex. Some aspects of leadership are personality based, some are situationally based; virtually all aspects have cultural elements; many aspects are linked to gender; some are linked to stability in group life and some to crisis.

A distinction should be made between leadership as a function that needs to be performed in working groups and the role of the social worker staff person. Members can and do capably provide part or all of their own leadership. One of the ways in which group workers can be helpful in working groups is to help the group identify, support, and work cooperatively with its own indigenous leadership. One of the strains that can arise for staff persons is the fact that group members and the staff person not only share a common human condition—this is, after all, the case in all groups—but also that frequently members of working groups are educated as well as or better than the staff member, have a variety of life experiences that the staff person may not have, speak in the idiom of the community or the organization that is the target of the group's actions, and may well have access to more and better resources than the professional does.

When the staff person carries some of the leadership responsibility, one should heed Kouzes and Posner's (2001) advice that "leadership isn't a place, it's a process . . . it's far healthier and more productive to start with the assumption that it's possible for everyone to lead. . . . Leadership is a relationship. . . . Leadership development is self-development" (p. 85). Slater (2001) points out, "People don't need to be controlled and manipulated to commit themselves to a heartfelt vision, and being controlled and manipulated tends to destroy that commitment. Those trained to a mechanistic world view often find it difficult to learn this" (p. 115).

Staffing a working group requires a capacity for aloneness, an ability to back off and see the group and its external environment in a thoughtful and perhaps a new way. It demands believing in the value of conflict and its nonviolent resolution, trusting the processes of the democratic microcosm, and fighting the natural tendency to do what feels good and to avoid what does not feel good.

ETHICAL AND MORAL ASPECTS OF SOCIAL WORK WITH WORKING GROUPS

Working effectively with working groups requires some sense of one's own and of others' dignity, but certainly not immunity from human failings. Like other people, social workers who work in working groups get tired, get annoyed, do not appreciate being the targets of blame, and may have emotional difficulties. Although all feelings are acceptable for professionals in groups, all behaviors certainly are not. Understanding and guarding strictly the boundary between feelings and behaviors entails applying professional skill and observing professional ethics. Two examples may make this point clearer. It is quite normal for professional staff to feel attracted to certain group members. However, it is unacceptable to act on these feelings. Neither is it acceptable to favor some group members over others, nor to undertake intimate relationships with a group member while one is responsible for maintaining a professional relationship. Conversely, it is normal for a professional to like some group members less than others, even to dislike some group members. Again, the principle is that the feeling is acceptable, perhaps to be worked through by introspection, perhaps not. Hostile behavior toward such group members is unacceptable and is contrary to professional ethics.

Effective group work with working groups requires a self-reflective stance, resiliency, and an ability to apologize for mistakes, together with a kind of indestructibility so far as the group is concerned. Operationally, indestructibility means that one tries hard not to lose self-control, regardless of the provocations; one does not engage in temper tantrums, in interpersonal violence, or in dramatic scenes involving leaving the group or returning to it. One bears in mind to the maximum extent possible that group successes are the group's, including but not limited to the professional, and that group failures likewise are the group's, again including but not limited to the professional. Social work with working groups demands a sort of psychological sturdiness, not being able to be recruited into interpersonal conspiracies on the one hand and being able to dampen one's mood swings on the other.

Working groups can be quite challenging for social workers. They often require that one come to grips with the profession's commitment to seeking social justice. One must work toward a certain moral authority without denying one's own limitations. Working

groups require the ability to participate, to learn, to lead, and to teach, all depending on the needs of the group, its members, and its tasks, rather than on needs that arise within the staff person.

Expertise in the content of the group has some importance. Knowing how to assess an organization or a community is an important skill, so ability and experience at quick, small-scale survey research can be a distinct asset. But because it is impossible for anyone, as a staff person, to have expertise in all areas that a working group may need, and because there may well be someone in the group whose expertise surpasses the social worker's, the staff person does not need to be an expert on everything that comes up in the group's life. An example that comes up in virtually every group at this time has to do with expertise in using computer technology. The competition that arises when group members compare their own experiences and the status that technological sophistication can give to a group member who may otherwise have little influence or power in the group are common current trends.

When he first laid out the functions of the group worker in his classic article, "The Social Worker in the Group," William Schwartz (1961) included "lending a vision" of how things could be, a vision that engendered hope for the future among the group members. It remains one of the major functions for a social worker in working groups.

The ability to provide staff leadership to a working group is related to personality, experience, maturity, managing situational demands, and moral involvement (Balgopal & Vassil, 1983). What also needs to be emphasized is the importance of character, courage, and living with ambiguities in today's social milieu.

Personal and organizational immoral behaviors, such as diversion of philanthropic resources to personal enrichment and high living and embezzlement and fraud on the part of professional social workers, reflect similar behavior on the part of organizational leaders in the for-profit sector of the economy (Axelrod, 2003; Pearlstein, 2003; Vogel, 2002–2003). In this atmosphere, we think it makes particular sense to teach, reinforce, and uphold the Code of Ethics (National Association of Social Workers, 2008). Leaders of working groups must take seriously the Code of Ethics and one's responsibility to act in accordance with it. Northen and Kurland (2001) refer to relationship as the core of social work practice with groups. We underscore that these relationships need to be based on trust, truth, and confidence between group members and professional social work staff.

EFFECTIVE METHODS FOR WORKING WITH WORKING GROUPS

Agendas, minutes, notices of meetings, reminders, schedules, follow-up with nonattendees—these are the day-to-day caretaking instruments for working groups. Tropman (2014) has done a fine job of developing principles for conducting effective meetings; one ignores his advice at great risk.

For staffing working groups, the following techniques, properly used and properly timed, can be effective.

1. *Silence*, not saying anything while behaving nonverbally in an accepting and interested way, is one way of permitting, compelling, or even requiring group members to work on their tasks. Expressing empathy, sometimes in the form of sympathetically asking for clarification or more information, is a way of relating to individual members, a subgroup, or the work group as a whole.

2. *Mirroring or reflecting feelings*, as well as providing client feedback, can lead to group reassessment, to recentering, to clearing away obstacles and enabling the group to move ahead. One needs to be concerned with not overloading one or more group members in this process. Social workers are not the only people who find taking criticism difficult at times.

3. *Exploring, probing, and questioning*, especially through using open-ended questions, is often useful for a variety of purposes in addition to the stated requests for information. For example, one way to involve group members who seem under- or uninvolved is to ask for their opinions. Sometimes it helps to check out what appears to be unanimity but may just be hesitation on the part of some members to disagree with a predominant point of view or to risk others' disapproval.

4. It can be useful at times to *give directions or advice*. This is particularly the case when working groups are clearly formed and have developed confidence in their own abilities. When one knows one's group thoroughly, it often makes sense to move right ahead with a piece of advice or a forceful suggestion. Some danger exists, though, in the staff person playing the "politics of expertise" (Benveniste, 1972) too frequently. If a staff person gives direct advice more than twice in a particular meeting, that person should examine closely the motivations and effects of the behavior. *Universalizing* and its close relative, *connecting points of view*, are ways to help groups move toward decisions made in a win-win manner.

5. *Confrontation* is a term that actually means sharing with a group your view of where a particular action or inaction or decision is likely to lead. It does not necessarily connote interpersonal conflict, let alone hostility. Again, this term comes close here to Schwartz's (1961) concept "lending a vision." Schwartz proposed that one of the functions of the worker was to share with the group a view of future probabilities of outcomes that might result from the group's action.

6. *Support* can refer to a variety of actions in a group. One can support a group member's right to express a point of view, one can support the point of view presented, one can support a group member while supporting his or her point of view, or one can support the manner in which a group has dealt with its member's suggestion.

7. *Modeling, coaching, and shaping* are useful training techniques, ideally suited to rehearsing behaviors, choosing among alternative strategies, and the like. It needs to be possible for a group member not to take part in any particular activity or simulation.

8. *Supposals* are a form of using imagination to solve problems. They are ways to practice looking ahead, thinking about possible outcomes of a course of action, at minimum risk. Supposals begin with the statement, "Let's suppose [we do this, we do that, we don't take a stand, we don't allocate money for this service in the budget, etc.]. What's likely to happen? Would we still have [a particular political figure's, say] support?"

9. *Summarizing and focusing, partializing, sequencing, pacing, and grading* are all ways of either synthesizing, that is, putting together the bits and pieces of a problem to form a whole, or analyzing, that is, taking apart a problem to better understand the bits and pieces.

10. *Decentering* and *setting limits* are the two sides of the same coin; the first refers to getting apathetic members, subgroups, and groups off dead center, the second to reinforcing limits for the sake of order, reducing noise level, or reducing the level of potential or actual danger. Another way of thinking about these techniques is that the first is geared

toward increasing the activity level, and sometimes the anxiety level as well, within a group, whereas the second seeks to reduce one or both of these levels.

11. *Dividing into smaller subgroups*, sometimes called “buzz groups,” may be a useful technique to get ideas and suggestions out into the open, to “brainstorm,” and to seek alternative solutions.

12. Though most working groups operate informally most of the time, *a thorough knowledge of the concepts and techniques of parliamentary procedure* should be part of a staff member’s armamentarium, to be called on and referred to with the group as needed (Ramey, 1993).

These are only some of the techniques that are applicable in working groups. They are potential elements in the professional role behavior of the staff person and may be used by group members as well. There are also some aspects of staffing working groups that deserve mention, even though they cannot be found in most lists of techniques. Social workers should be aware of their own interpersonal needs or, for that matter, their own needs for accomplishment, recognition, and even money. Ephross (1983) warned of the construction of a professional self that emphasizes service to others and concern with others but is silent on the subject of concern with one’s own needs, aspirations, and life stage as a person.

Working effectively with others in groups requires, in our view, that one’s own needs are being met to a reasonable extent. Yet, in some human service organizations, concern with the needs of staff is somehow judged to be illegitimate or a sign of weakness, of violating the ethics of the profession, when it is in fact the opposite, a way of fulfilling professional ethics. Given the burgeoning literature on the health needs of caregivers and the need to devote attention to avoiding tangled relationships (e.g., Haas & Malouf, 1995; Reamer, 2001; Scott & Hawk, 1986), social workers have a responsibility to members of working groups, to themselves, and to their own families and those significant in their lives to pay attention to meeting their own needs. Working with groups can drain one’s relationship capacity, one’s psychic energy, and, at times, one’s physical energy as well.

We conclude with brief considerations of two elements of professional practice with working groups—one common to work with all kinds of groups and one particular to social work practice in working groups. The common element is that all group work practice rests on *conscious use of self*. Each piece of professional behavior is a miniature research process, based on a hypothesis that the behavior will lead to a desired outcome, testing the hypothesis by the action, then concluding from one’s data analysis that the hypothesis has been supported or supplanted by a revised or new hypothesis. For students and beginning practitioners, the process is apparent, sometimes painfully so. For experienced practitioners, it becomes almost second nature, and it is repeated at each group meeting, each contact with a group member between meetings, and each piece of planning on the part of the staff person.

The element that is distinctive to much work with working groups is the equality, sometimes the superior status, of group members vis-à-vis the staff person. As noted earlier, it is a common experience for one, more, or all of the members of a working group to be equally as educated as the staff person, sometimes better educated; to be richer than the staff person (regrettably not usually difficult, given the levels of many social work salaries), or to possess more expertise about particular problems facing a group or particular tasks that the group needs to accomplish. This relationship dynamic is an important one that should be part of the consciousness of social workers who work in and with working groups and one with which the social worker needs to be comfortable. The skills of group members should

be viewed as sources of help for the group as a whole, not as problems or challenges for the professional staff member.

EPILOGUE

Some of the most important decisions and events in the career of a professional social worker take place in working groups, often in groups in which professionals serve as members, chairs, staff persons, or all three. As careers progress, even the most devoted clinical social work practitioners find an increasing proportion of their time and effort being spent in working groups. "Administration involves a large and crucial component of group participation and group leadership" (Ephross & Vassil, 2005, p. 2). Working groups, their processes, and their decisions are influential and important in the lives of citizens, as they are in the lives of professionals. Together, working groups constitute a significant part of the fabric of our society, and knowing how to work in them, lead them, staff them, and bring about change in them is essential to improving the effectiveness of social services and work toward the equity and social justice that are the goals of social work.

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PART VI

GROUP WORK RESEARCH AND EVALUATION

INTRODUCTION

As we have stressed in the introduction to this book, we believe progress in group work practice and theory requires a partnership between researchers and practitioners. For this reason, we have devoted this section to research on group work practice. The authors of these chapters recognize that research and evaluation in group work is a challenging task for many reasons. A critical issue pertains to the many system levels involved in group work, as discussed in Chapter 2 of this volume: the individual member, the practitioner or practitioners, the subgroups within the group, the group as an entity, the organization within which the group is located and which is usually the sponsor of the group, and the community and other environmental systems (including the members' families) with which the group and its members interact. Depending on the research or evaluation questions, any or all of these systems must be considered, and a research design strategy must be developed to do this. Another challenge is to devise an approach to measurement that will be feasible for respondents and that provides a valid answer to the research or evaluation questions.¹

Chapter 29 discusses ways of evaluating group work. Chapter 30 considers the measurement issues faced by group work researchers. Chapter 31 presents information on the rapidly developing field of qualitative research on group work. Finally, Chapter 32 discusses in detail the ways that intervention research can be done in group work, including both quantitative and qualitative methodologies.

NOTE

1. One of us (C. D. G.), along with some of the contributors to this book, has recently published one of the first books to tackle research issues faced by social workers with groups and group work researchers (Garvin, Tolman, & Macgowan, 2016).

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Garvin, C. D., Tolman, R. M., & Macgowan, M. J. (2016). *Group work research*. New York: Oxford University Press.

CHAPTER 29

Evaluation and Research Design

LARRY M. GANT

This chapter describes the evaluation of various group approaches found in published academic and professional literature. First presented is a brief context for the chapter. This is followed by a brief overview of the distinctions between program evaluation and clinical research. The balance of the chapter is devoted to a discussion of evaluation approaches and findings across published accounts of group work interventions. The chapter concludes with an assessment of the current state of evidence-based group work interventions and suggestions for future directions.

CONTEXT FOR THE CHAPTER

Fiscal resources for social supportive services continue the decline initiated by the Reagan administration's migration to locally controlled and administered block grants in the early 1980s. The "flat funding" approach more recently favored by both Republican and Democratic presidential administrations neither eliminates nor increases program resources. By holding dollar amounts constant, programs can be "preserved," but their budgets continually decline to levels less than inflation and costs of living. A push for accountability and funding the most effective programs possible continues to increase the use of benchmark programs, outcome studies, and best practices. These renewed calls for "research-based practice" or "evidence-based practice" mandate that program providers demonstrate significant change beyond chance (the purview of clinical research) or at the very least provide evidence that answers the question "does it work or not?" with or (more likely) without use of randomized clinical trials or design sensitivity analysis (the purview of evaluation). Calls for time-limited interventions further underscore the emphasis on "effective" programs. There continues to be little evidence to suggest program funders will return to the earlier times of funding programs that "should" and "ought to" work. Programs—at least those without champions and public advocates—will need to demonstrate effectiveness or not be funded.

Or so the narrative goes. If this were actually the case in group work—if group workers were indeed being required to demonstrate efficacy (or be defunded), there should be evidence of this urgency with (1) a substantial increase in evaluation studies of group work, as well as (2) an increased number of systematic reviews of group work efficacy. Reviews of literature and articles suggest instead a rather modest continuation of group work evaluation (Garvin, Tolman, & Macgowan, 2015) and a few more systemic reviews of intervention efficacy (e.g., Allen-Meares, Montgomery, & Kim, 2013; Bullock & Banningan, 2011; Macgowan & Wong, 2014; Ramsey & Montgomery, 2014; Wike et al., 2014). There is, however, a very interesting development in the construction of a framework for creating, using, learning from, and consuming small-group research and evaluation—essential to establishing a culture of creating, revising, and using useful and productive group work methods. Many of these researchers argue that the 21st century is the time to develop a culture around creating and evaluating group work (Soydan & Palinkas, 2014). They would argue that the critiques of evidence-based group work are premature and espouse a scientism that is at least very problematic for contextually grounded group work (McNeece & Thyer, 2004; Mullen, 2009; Thyer, 2004).

The current chapter provides responses to these alternatives, updates the previous entry, considers the information, and identifies suggestions and possibilities. I begin with a definition of terms, starting with a brief listing of the tasks of group work. I move next to a topic of perennial challenge—where perhaps no greater difficulty or confusion continues to exist—distinguishing program evaluation from clinical research (Thyer, 2004). This is important as most systematic reviews of interventions continue to value clinical research (with randomized controlled conditions, sample size computations, and power analysis) over more outcome-based program evaluation work. Yet, how many group work initiatives or processes receive rigorous program evaluation?

INTERVENTION TASKS OF GROUP WORK

Groups are used to help people address a variety of intervention tasks. Garvin's (1997) list of intervention tasks continues to be canonical:

1. *Identifying problem to be solved.* Groups can increase personal awareness of problems or issues without personal accusation or prejudgment and with a normalization and destigmatization of the issue. Depending on the approach, groups can facilitate the personal location of problem cause, problem resolution, or both.
2. *Deciding to solve the problem.* In groups, people with low motivation to resolve problem issues can find ways and support to increase motivational levels to address the problem or issue.
3. *Planning for problem solving.* Persons learn in groups how to identify problems and employ problem-solving methods to generate, assess, and implement solutions.
4. *Active problem solving.* Groups can provide a wide variety of strategies for change, along with ways to implement and monitor the change efforts.
5. *Maintaining problem-solving strategies.* Groups can be more effective than individuals in working to sustain and support personal change efforts. Groups can also provide support in the face of personal lapse or relapse.

Determining the effectiveness of these tasks is nearly completely context dependent on the demographic composition of the group, the operationalization of the problem,

community location and resources, identification of solution set, and ability of the group to implement change (Smock, 2004). The nature of the context dependence for small-group research renders the canons of randomized clinical trials extremely difficult to navigate, pay for, and deploy (Klein, 2015; Mullen, 2009; Ornish, 2015).

DISTINGUISHING PROGRAM EVALUATION FROM CLINICAL RESEARCH

There is perhaps no more confusing clash of terms to lay and professional audiences involved in the “evidence-based practice” debate than that of *program evaluation* with *clinical research*. In the past, evaluators have done a better task of speaking to each other than to other populations, but recent texts suggest enhanced outreach to thoughtful lay audiences (e.g., Fetterman & Kaftarian, 2014; Grinnell & Unrau, 2011; Patton, 2011). Nonetheless, a brief discussion of evaluation here complements the superb discussion of clinical research found elsewhere in this volume.

The purpose of evaluation, according to Rossi, Lipsey, and Freeman (2003, p. 3) is to “study, appraise, and help improve social programs.” Piontek (2003) further develops a checklist of program evaluation purposes that includes uses of it to (1) decide whether to accept a new program or service; (2) decide whether to continue, change, or eliminate an existing program or service; (3) examine the uniformity of program implementation with program plan; (4) assess the overall value of a program; or (5) help funders and stakeholders determine the ways in which issues are being solved or needs met. More specifically, program evaluation “is the systematic collection of information about the activities, characteristics and outcomes of programs to make judgments, and/or inform decisions about future programming” (Piontek, 2003, p. 4). *Formative evaluation* is typically conducted during the operation of a program, providing information useful in improving and enhancing the program. *Outcome and impact evaluations* are conducted at the end of a program and provide judgments about the effectiveness, worth, or merit of a program or activity.

Program evaluation differs from basic scientific research in at least two important ways: (1) the purpose of data collection and (2) the standards for judging validity. As to the *purpose of data collection*, program evaluation is done with an intent to inform decisions, clarify options, specify improvements, and provide information about programs and policies within the social and political context. Research is done to seek out new knowledge, engage in theory testing, confirm or disconfirm hypotheses, and generalize findings (Fetterman & Kaftarian, 2014; Patton, 2011; Rossi et al., 2003; Royse, 2010).

For the purposes of this discussion, validity can be operationally defined as the work’s being accepted as accurate, reliable, and exact (Thyer, 2004). The validity of scientific research relies primarily on the methods of design, data collection, and analysis strategies used. The validity of program evaluation includes both the methodology and the approach of the evaluation, the role of the evaluator, and the presentation of results and findings (Fetterman & Kaftarian, 2014). The evaluation and the evaluator must both be perceived as reliable for the evaluation to be optimally valued (Grinnell & Unrau, 2011).

EVALUATING GROUP WORK: REFLECTIONS ON REVIEWS

Evaluations of group work can be quite complex; group-level interventions can be evaluated on a number of levels. For example, the evaluation can be taken from the perspective of the client, the group leader, or both. The evaluation can focus on individual change,

group process, or the influence of the leader on the group interactions. Finally, group work evaluations can vary in purpose, for example, accreditation, compliance, effectiveness, efficiency, equity, process, and impact (Patton, 2011). Discussions of the evidence base of group work method strictly focused on systematic reviews or meta-analytic approaches consistently yields low numbers of articles that comply with the quite stringent empirical requirements characteristic of systematic reviews and meta-analyses (Rossi et al., 2003). The earlier version of this chapter included a very modest selective inquiry of empirically based work appearing in (largely) social work research journals (Gant, 2004). At that time, the review of research concluded that the number of high-quality studies—requiring high investment costs—was quite small, but with compelling findings. Far more qualitative case studies were noted. These case studies were sophisticated and thoughtful in their own right and raised issues of method, context, and operationalization of approaches. These were fabulously rich articles, but at times the titles of the studies suggested more of an empirical quantitative analysis than actually existed in the report. Given the cost and investment of many types of resources, it was argued that the research base was small but existent and that context studies were also very important in deployment, modifications, and so forth.

Since that review in 2004, a few additional meta-analyses have been published, with the common concerns for scarcity of studies with empirically robust designs, operationalizations, power analysis, and the resultant conclusion that the evidence base of group work designs continues to be lacking (e.g., Allen-Meares et al., 2013; Bullock & Bannigan, 2011; Macgowan & Wong, 2014; Ramsey & Montgomery, 2014). Bullock and Bannigan (2011) deployed a sophisticated process for identifying 136 potentially relevant published studies, used traditional evidence-based criteria to reduce the number of articles meeting minimal but sufficient standards to 3, and reported sufficient problems in comparisons across method to render any evidence-based practice inferences impossible. Not surprisingly, the authors concluded that “large-scale rigorous research, in the form of randomized controlled trials, is urgently needed to identify whether activity-based group work is effective” (Bullock & Bannigan, 2011, p. 257).

Allen-Meares and colleagues (2013) reviewed published evaluations of school-based group interventions. In the 18 studies identified and reviewed, many positive effect sizes were found on group-level interventions treating outcomes that included sexual health, aggression, self-esteem, school attendance, identity, and depression. Macgowan and Wong’s (2014) analysis of 51 group work studies using single-case designs yields impressive efficacy-based evidence with a much maligned but conceptually powerful single-subject design (Gast & Ledford, 2014; Macgowan & Wong, 2014). Ramsey and Montgomery (2014) reviewed technology-based group interventions; again, while the number of “eligible” studies was small ($n = 6$), the intervention effects on outcomes associated with reduction in anxiety symptoms, impact in different settings (homes, court facilities, mental health centers) and acceptability and feasibility of implementing the group-level interventions were impressive and robust. Consistent with the findings of Garvin and colleagues (2015), these well-designed reviews reflect—for the most part—that the small number of clinically designed studies of group work interventions yields compelling findings and, if anything, encourages future studies with different types of evaluation and research designs. Few, if any, of these studies reported a classic large-scale randomized clinical study.

In closing this section of the chapter, please note a very different approach to the evaluation of group work—as a paradigm for evidence-based practice not within the context of randomized clinical trials but within a consultative process and approach between a

practitioner and client, group, or population (Gibbs, 2003; Grinnell & Unrau, 2011; McNeece & Thyer, 2004; Mullen, 2009; Soydan & Palinkas, 2014; Thyer, 2004). Mullen (2009) efficiently summarizes this approach:

Evidence-based social work practice (EBSWP) may be defined as a professional decision-making process in which social workers and their clients systematically make intervention choices using practitioner expertise to identify (1) client conditions, needs, circumstances, preferences and values; (2) best evidence about intervention options, including potential risk and benefit likelihoods; and (3) contextual resources and constraints bearing on intervention options. Intervention choices refer to action options about how to assess client conditions and circumstances, how to provide services, and how to evaluate the process and outcomes of services. Clients can be individuals, families, groups, communities, or large populations. Best evidence includes findings from scientific studies as well as from other reliable sources considered to be of highest quality, strength, and relevance.

Other responses are informative and consistent with this perspective (Bellamy, Bledsoe, & Traube, 2006; Manuel, Mullen, Fang, Bellamy, & Bledsoe, 2009; Soydan & Palinkas, 2014; Wike et al., 2014). A recent discussion of the importance—and the state—of group work research is found in Garvin and colleagues (2015). After a thoughtful presentation and defense of a tripartite model of evidence-based group work, their conclusion focuses on a generally positive and progressive perspective on the continued development and evolution of evidence-based practice across types of evidence, across mixed models of research and evaluation, and across fields and contexts (Garvin et al., 2015). Although much work remains, much has been done—and is in process.

There is no question that the challenges of evaluating group work interventions are being addressed (Garvin et al., 2015). For some authors the pace is slower than expected; for others, the pace continues to evolve and accelerate. The reality is that the expected “gold standard” methodology is expensive and requires expertise not typically available in community-based organizations or agencies. Beyond this, the deployment of randomized clinical trials in natural settings of communities and organizations is extremely difficult and time-consuming. It is not inexpensive nor easy to do; it requires trained personnel and demands a high level of continuous oversight and monitoring. High-quality evaluations are thus possible but expensive and resource intensive (Ornish, 2015). Funders and other audiences demanding clinical research designs need to understand this and provide funds for the very necessary, difficult, and expensive types of evaluation designs they demand. There are no shortcuts to quality evaluation. However, the funding horizon does not appear to be consistent with the call and demands for these types of evaluation designs.

ASSESSMENT AND FUTURE TASKS: WHAT MAKES A GOOD EVALUATION OF GROUP WORK PRACTICE?

What, then, constitutes good evaluation of group practice? There continue to be very few surprises in generating a classic list of components, including:

- Background and significance
- Clear procedures and methodology
- Stated reliability and validity of measures and data collection
- Clear discussion of client recruitment

- Operationalization of organizational process
- Detailed methodological procedures
- Accessible and appropriate qualitative–quantitative data analysis and presentation, including effect size or percent variance explained
- Clear connections between findings, analysis, and evaluation questions.

The preceding list can be used for qualitative or quantitative analysis or an integrated mixed-methods approach (Cresswell, 2013). While both multiple forms of inquiry have their benefits, at least for now quantitative methods have priority in the ultimate empirical determination of program effect, although this continues to be focus of passionate discussion. There are compelling and thoughtful challenges to the use of statistical significance (Seife, 2015), evidence-based medicine (Klein, 2015), multiple regression as a means of discovering causality (Nisbett, 2015), and large randomized controlled studies (Ornish, 2015). Increasingly, qualitative methodologies can be quantified, analyzed, and incorporated as quantitative variables in analysis (Corbin & Strauss, 2014; Cresswell, 2013). We leave to wiser heads the extensive and unresolved discussion of the merits and demerits of quantifying qualitative data (Corbin & Strauss, 2014; Cresswell 2013). Quasi-experimental designs—the hallmark of most program evaluations (Rossi et al., 2003)—have extraordinary merit, value, and worth. They should continue to be used extensively and supplemented with sophisticated statistical analysis and good, solid evaluation questions.

CONCLUSION

The empirical investigations of group research, characterized by randomized clinical studies, is discussed elsewhere (e.g., Cresswell, 2013; Royse, 2010; Seife, 2015; Soydan & Palinkas, 2014; Thyer, 2004). The evaluation of group research continues, perhaps with fewer studies than might be desirable, but with studies nonetheless. The number of studies grows somewhat more slowly than desired—but there is growth. The evaluation approaches for group work range from formative to summative, and from exploratory to confirmative. In the first two decades of the 21st century, traditions of evaluating group work approaches continue, with findings closely derived from analyses and context. The effect of group work approaches is increasingly well demonstrated. Multiple models of evaluation approaches are incubating and germinating (Garvin et al., 2015). Nonetheless, the current level of analysis of group work evaluations offers a sufficient if qualified “yes” to the question, “is group work intervention effective?” Group work in general continues to await better answers—and better thinking—to the follow-up question, “but effective compared to what?” Perhaps an initial response can be found in a paraphrase of Kosko’s (2015, p. 540) recommendation to science and scientists: “Is social group work effective—and compared to what? Perhaps social work—and social group work—needs to take seriously its favorite answer: It depends.”

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CHAPTER 30

Measurement Issues

RANDY MAGEN

Examining groups from a systems perspective may be natural for contemporary social workers. The systems perspective, or group-as-a-whole orientation, provides a solid conceptual foundation for understanding groups (Agazarian, 1992). However, to engage in evidence-based group work practice or to conduct research on groups, abstract group concepts must be conceptualized and operationalized (Engel & Schutt, 2009). In qualitative approaches the conceptualization occurs after data have been collected to extract meaning from the observations. In quantitative approaches, operationalization is the process of assigning values to observable indicators of constructs prior to collecting data (Bonito, Ruppel, & Keyton, 2012). Whether inductive or deductive, the collection of observations is the process of measurement. This chapter discusses measurement issues in groups.

GROUP WORK IN THE CONTEXT OF MEASUREMENT

It is an ethical mandate for social workers to “protect clients from harm” (National Association of Social Workers, 2008, 1.04(c)). Research has pointed out the potentially harmful effects of participating in a group (Coyne, 1999; Lieberman, Yalom, & Miles, 1973; Smokowski, Rose, Todar, & Reardon, 1999). It is only through systematic evaluation that practitioners can understand the effects of their groups and be able to, in the least, refute the claim that the group caused harm. Measurement generates the data necessary to systematically evaluate a group. Garvin (1997) also points out that evaluation is necessary in our current political climate, which stresses accountability.

Critics of the use of measures in social work practice argue that measurement is reductionistic and has little relevance to the complexities of social work practice (Goldstein, 1992; Witkin, 1996). Challengers of evidence-based practice argue that the focus on data devalues clinical experience (Williams & Garner, 2002). However, Gibbs (2003, p. 16) writes that measurement is not a substitute for practitioner judgment but rather lies at the “intersection between experience, the client’s preferences and current best evidence.”

Measures are tools for the group work practitioner to utilize in collecting data to understand the effects of a group. There are two general types of effects that can be measured. The first are the effects of the intervention on members' goals—measurement of the outcome of the group. Generally, the question being asked of the data collected through the use of outcome measures is, Did the client change?

The second type of effects are measures of the group conditions, often referred to as measures of group processes. The main question being asked of data collected from group process measures is, Do the group conditions exist that are necessary for clients to make progress toward their goals? The general failure in the clinical literature to link group processes with outcomes is a long-standing and serious problem. Methodologically, group processes can confound outcome. Rose, Tolman, and Tallant (1985) point out that differences between two interventions may be misattributed to content differences when in fact the differences were due to a failure to achieve optimal group processes in one condition.

In individually based practice, what can be measured is limited to the client, the practitioner, and the interactions between the practitioner and the client. In groups, what can be measured expands geometrically with every group member because each individual, dyad, triad, and so on can be the target of measurement. For example, in a group of six people in which one of the members is the designated leader, there are six individuals, 15 dyads, 20 triads, 15 subgroups of four members, six subgroups of five members, and the entire group of six that can be the focus of measurement. This assumes, of course, that measurement of the dyads, triads, or subgroups is meaningful and useful.

Like any tool, measures can be used carelessly and foolishly. Using measures that are a burden because of their complexity, length, or relevance is foolish. Similarly, using measures without a clear idea of how they will be used to assist clients or leaders is careless.

INTERVENTION

The use of measures in groups is not limited to any particular approach to group work. As is shown below, qualitative and quantitative measures have been utilized in psychodynamic and behaviorally oriented groups, in remedial and reciprocal model groups, and in leader-centered and self-help groups. However, some methodologies and types of measures are more syntonic, with specific approaches to group work. For example, Kurtz (1997) advises that qualitative methods and participatory action research are best suited to self-help groups.

Empirical Evidence and Theoretical Base

Five issues need to be addressed before using any measure in groups. These issues are related to the unit of analysis, definition of concepts, individualization of measurement, reliability, and validity.

Unit of Analysis

The unit-of-analysis issue may be the most commonly ignored methodological quagmire in group work research. The basic idea is that the unit measured should be the unit analyzed. However, it is common for group work researchers to collect data on one level (e.g., individuals) and infer something about a different system level (e.g., dyads, triads, or a group). There are many dangers with this practice. First is the reductionist fallacy (Engel & Schutt,

2009), a common but suspect practice in which individual-level data are collected yet analyzed and reported in terms of the group. Another problem with using individual data to describe the group as a whole relates to errors in aggregating the data. Group workers often report the mean of the group members' individual scores as the score for the group. Glisson (1986) pointed out the dangers of this approach: Depending on the distribution of individual scores, this procedure can either overestimate or underestimate the group score.

Analyzing individual scores to draw conclusions about the group rests on the assumption that individual data values are independent. However, part of the therapeutic impact of a group is that members influence each other; thus scores on measurement instruments are affected by what other group members say and do—the data are not independent observations. The violation of the assumption of independence can lead to bias in standard error estimates and erroneous results in statistical tests (Barcikowski, 1981; Pollack, 1998).

Similar is the ecological fallacy, less common in the literature than the reductionist fallacy but equally suspect, in which group-level data are used to make statements about individuals (Engel & Schutt, 2009). Conceptually, based on systems theory, the group is understood as more than the sum of the individuals; therefore, we need data at multiple levels and/or analytic approaches that accurately describe the different levels. Although statistical analyses to deal with this problem are beyond the scope of this chapter, two solutions that have been suggested are using nested designs (Morran, Robison, & Hulse-Killacky, 1990) and hierarchical linear modeling (Pollack, 1998). Bonito and colleagues (2012) point out that analyses at both the group and individual levels are precisely what are needed to understand the interaction between individuals and groups.

In some group work research, the individual level of analysis may be less important than other levels. For example, Maton (1993) proposed an ecological paradigm for understanding self-help groups within the context of communities and other large systems. In this model, if self-help groups are conceptualized as community organizations (Kurtz, 1997), then community-level variables such as human service budgets, prevalence of focal problems, and population stability affect group effectiveness and need to be measured.

Finally, the practice of aggregating individual scores as measures of group process is also suspect on conceptual grounds, given that almost all definitions of group processes are linked to the group rather than to individuals.

Definitions of Concepts

Measurement does not start with the selection of an instrument but rather with clear definitions of the concepts to be measured. Bednar and Kaul (1994, p. 633), in reviewing 50 years of group research, were highly critical of the state of measurement in group work research. Instead of more rigorous research designs, they called on researchers and practitioners to carefully observe and describe groups so that specific measurement tools could be created. Bednar and Kaul's critique should be seen as a warning to anyone measuring aspects of group work. The usefulness of any measure is dependent on the clarity of the concept it is describing.

In group work practice and research, the difficulty in defining concepts is most pronounced in measures of group process. Although there have been rich descriptions of various group processes, little agreement exists about even the most basic phenomena. For example, on the one hand, there is widespread agreement that cohesion is a necessary group process for the functioning of effective groups. High cohesiveness has been linked to therapeutic change (Dies & Teleska, 1985, p. 120), whereas low cohesiveness has been shown to

correlate highly with members dropping out of groups (Lieberman et al., 1973). A meta-analysis of group cohesion research by Burlingame, McClelland, and Alonso (2011) found, across 40 studies, a positive, medium-size effect between cohesion and outcome. On the other hand, there is little agreement about how to define cohesion, as illustrated by the following definitions:

- The total field of forces which act on members to remain in the group (Festinger, Schachter, & Back, 1950, p. 164).
- Attraction to the group (Lieberman et al., 1973, p. 302).
- The composite of member–member, member–therapist, and member–group relations (Fuhman & Barlow, 1983, p. 263).
- The degree of members’ involvement in and commitment to the group and the concern and friendship they show for one another (Moos, 1986, p. 2).

For group work researchers and practitioners, the first step in measurement is a clear conceptual definition of the concept. This leads directly to the operationalization of the concept. Given the variation in conceptual definitions of cohesion, it should be no surprise that Burlingame and colleagues (2011) identified nine commonly used measures of group cohesion in the published research literature.

Individualization of Measurement

A common research design for investigating the effect of a group intervention tests the hypothesis that the group members’ mean score on an outcome measure is significantly different from pretest to posttest or is significantly different from scores of members in control or comparison groups. For example, to test whether a cognitive-behavioral group reduces members’ levels of depression, a researcher could administer the Beck Depression Inventory (BDI) prior to the beginning of the group and again at the end of the group. The researcher could then perform a matched-pairs *t*-test, assuming adequate sample size, to reject the null hypothesis that there was no difference in scores on the BDI from pretest to posttest. The purpose of this research is to show that a cognitive-behavioral group intervention can reduce depression and develop knowledge generalizable beyond the group being studied.

Utilizing a norm-based instrument such as the BDI allows researchers and practitioners to compare their samples to various published norms. The practitioner reading the report about the cognitive-behavioral intervention has a standard against which to evaluate the level of group members’ depression. Measures that allow comparison to norms are referred to as *nomothetic* measures.

Nomothetic measures also have disadvantages. First, norm-based measures are often indirect proxy measures of client troubles and, as a result, are difficult to use in evaluating individual reactions and the importance participants attach to their difficulties. Norm-based measures are often insensitive to small changes. Nomothetic explanations that rely on tests of sample means provide us with little or no information about what happened to an individual client. Average scores can underestimate clinically significant changes when the effect of treatment is variable within treatments (i.e., when there is large within-subject variability). Furthermore, the imposed significance levels associated with statistical tests often have little relevance to clinical practice (Jacobson, Follette, & Ravenstorf, 1984). In fact, with a large number of participants, results can be statistically significant even when the effectiveness of an intervention is “weak” (Barlow, Hayes, & Nelson, 1984). Adjuncts to the use of nomothetic measures are ideographic measures.

Ideographic measures are precise and sensitive indicators of individual change. Although not commonly reported in group work research, ideographic measures can be found in the behavioral literature associated with single-system research designs. Ideographic measures allow clients to select indicators of important problems and determine how to measure a successful outcome. Furthermore, some ideographic measures can measure progress, as well as success. Ideographic measures of outcome, discussed later, include goal attainment scaling and individualized rating scales (Bloom, Fischer, & Orme, 1999).

Researchers and practitioners often want to know not only whether a group intervention is effective but also for whom it was most effective. Clinical significance tests following statistical significance tests are a method for obtaining ideographic explanations of outcome. Several statistical tests have been suggested for evaluating clinical significance (Christensen & Mendoza, 1986; Jacobson et al., 1984, 1986; Jayaratne, 1990). The most useful of these statistics is the SC suggested by Christensen and Mendoza (1986), which yields a score, in standard deviation units, that indicates the magnitude of an individual subject's change on a measure. The SC statistic, used in conjunction with nomothetic explanations, can tell us not only whether the group was effective but also which individual members benefitted most from the intervention.

Reliability

A synonym for reliability is consistency. There are many different ways to assess the reliability of a measure; the most common of these are test–retest, split-half, internal consistency, and multiple forms. For measures involving observation, the assessment of reliability refers to the consistency between raters, known as interrater reliability. Three methods for computing interrater reliability are Cohen's kappa, the interclass correlation coefficient, and the percentage of agreement.

By convention, the agreed-on standard for a reliable measure is .80, or 80%. Clearly, the higher the reliability, the better, but researchers commonly use measures with reliabilities considerably lower than .80. It is important for researchers and practitioners to understand the reliability of any instrument utilized. At a minimum, basic reliability statistics should be calculated and reported.

Validity

Valid measures are accurate measures. There are two questions associated with evaluating the validity of a measure. First, is the instrument measuring what it is supposed to measure? Second, how well does the instrument measure what is intended? Valid measures are reliable, but reliable measures are not necessarily valid. As with reliability, there are many methods for assessing the validity of a measure. These methods include face validity, content validity, criterion validity (concurrent and predictive), and construct validity (convergent, discriminate, and convergent). Assessing the validity of a measure is a complex and difficult task involving both clear concepts and careful empirical research. Measures are never completely valid nor completely invalid. Generally, the more information that is available about the validity of a measure, the more faith the researcher or practitioner can have in its use.

Measures of Outcome

To select an outcome measure, the group practitioner or researcher needs to decide (1) what to measure, (2) how to measure it, and (3) who will collect the measurement data (or where

they will be collected). This process of selecting outcome measures can be conceptualized as a three-dimensional cube, with each question corresponding to one dimension of the cube. Within each dimension are specific domains to be measured, methods of measurement, and source of the data (see Figure 30.1). There are many ways to conceptualize the elements within each dimension; the elements identified in Figure 30.1 are one example. The conceptualization of elements within each dimension is influenced, at a minimum, by the purpose of the group and the clients' needs. Other considerations in conceptualizing what to measure, how to measure, and who will collect the measurement data include theoretical orientation, practicality, and feasibility.

The metaphor of the cube is also helpful in identifying whether data collection is multimethod and multisourced, what qualitative researchers refer to as *triangulation* (Berg, 1998). Multiple blocks within the cube containing data will indicate measures that are triangulated. However, not all measures can be triangulated; for example, some outcomes are covert, such as a change in cognitions. As a result, the cells in Figure 30.1 that correspond to cognitions can be collected only from the client. However, the measure of cognitions can be done by means of self-monitoring, via tests and checklists; through analog observations; or by way of interviews. Furthermore, the measure of cognitions can be either quantitative or qualitative.

In reality, practitioners and researchers rely on a few common methods for measuring client outcomes. Perhaps the most common of these tools are tests and checklists, primarily

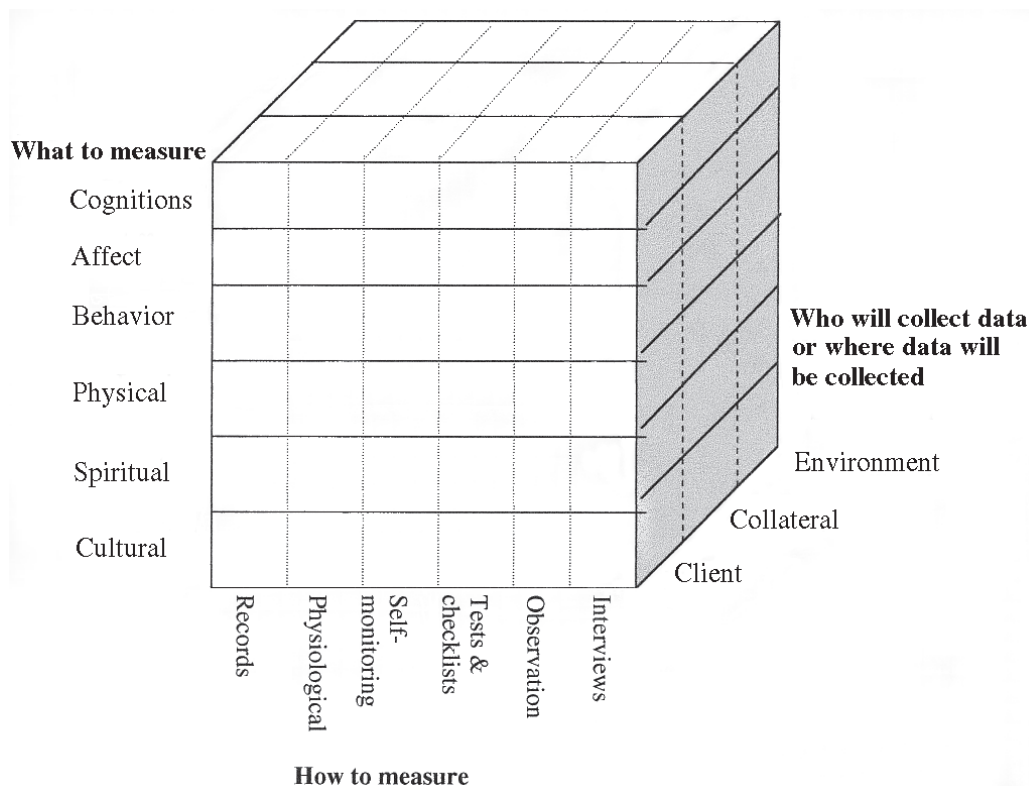


FIGURE 30.1. Triangulation matrix for selecting outcome measures.

norm-based instruments. Empirical research studies, in particular, rely on norm-based measures. Highly touted and extremely practical, but less utilized, are rapid assessment instruments such as those developed by Hudson (1990a, 1990b).

Another type of instrument, commonly used in children's social skills training groups, is sociometric ratings (see, e.g., Hepler, 1994). Originally developed by J. L. Moreno, the father of psychodrama, these checklists have high face validity and some evidence of reliability. In a school setting, children would be asked to rate, on a Likert scale, the likelihood of their playing with every other member of the classroom. The scores from the classroom would then be used to identify those children most isolated, as well as those most popular. These sociometric ratings are an assessment tool that can be used to compose groups that are heterogeneous. The sociometric ratings can also be repeated after the end of the group to test either ideographically or nomothetically for changes.

Two methods for obtaining ideographic measures of change are individualized rating scales (IRS) and goal attainment scaling (GAS). IRS, as described by Bloom and colleagues (1999), use a single scale with descriptive anchors to operationally define target problems. For example, a client in a support group for people who have breast cancer might use such a scale to rate the intensity of her fears about chemotherapy. The practitioner and client would work together to develop the labels for the 5–9 points found on the typical IRS. The client would then use this scale on a regular basis (e.g., weekly) to measure fears about chemotherapy.

Similar to IRS, GAS is frequently discussed in texts on measurement but rarely reported in the group work literature. GAS and IRS share many similarities. Both involve individualized ratings of a particular target. However, GAS is usually constructed on a scale from –2 to +2, with the level 0 being the client's current level of functioning. GAS, like IRS, can be used to measure not only outcome but also progress toward outcome (see, e.g., Magen & Rose, 1994).

Observation of group members' behavior within the group has long been used as material for social workers' case notes. One of the more common applications of systematic observation has been parent–child interactions (see, e.g., Whipple, 1999), in which structured observational systems are available. Observation of classroom behavior as reported by a teacher has also been used to assess outcome in some skills training groups. Finally, analog measures of behavior through role playing have been used both during group sessions and outside of the group as measures of outcome.

In the biopsychosocial perspective of social work, the biological realm often receives less attention than the psychological or social realms. As a result, scant attention has been given to the use of physiological measures of outcome in the group work literature. The one exception to this has been in the field of substance abuse, in which urinalysis is employed to supplement self-reports of abstinence. Several other simple physiological measures can be used to measure agitation or stress, such as heart and respiration rates. More complex measures of stress, such as cardiac output, have been used in social support and stress management groups by O'Brien and his colleagues (see, e.g., Anthony & O'Brien, 2002).

Self-monitoring as a method for obtaining outcome measurement is easily implemented but can have low reliability due to problems with adherence. It is useful for practitioners and researchers to follow guidelines for enhancing adherence when implementing self-monitored outcome measurements. For example, to improve self-reports of sexual behavior in HIV research, Weinhardt, Forsyth, Carey, Jaworski, and Durant (1998) suggested building in techniques that improve the recall of behavior, such as appointment books or calendars, and placing the burden of denial on the client. Rather than having participants record "if" a behavior occurred, the researchers asked them to record how many times a behavior

took place. From a research perspective, the reactive nature of self-monitoring can present a problem; however, in practice, this reactivity has been taken advantage of to strengthen an intervention. For example, in smoking cessation groups, monitoring the number of cigarettes smoked can help to reduce smoking.

Social workers are well trained in techniques of interviewing. Systematic collection of data during an interview can be used as a baseline for assessing outcome when compared with postgroup interview data. Interviews allow the collection of rich qualitative data that cannot be obtained from other measurement methods. For example, to understand the effect of a self-help group in preventing drug use and improving client's lives, Felix-Ortiz, Salazar, Gonzalez, Sorensen, and Plock (2000) interviewed 7 of 14 members participating in a self-help group at a methadone maintenance clinic. Whereas drug use and quality of life can be measured using other methods (e.g., tests and checklists), these interviews provided data on what the clients perceived to be the value of the group in contributing to their personal changes, a link that would be difficult to make using written measures.

Existing records may contain all the types of data listed here, as well as time-series data. Intake forms and other routinely collected agency records may be the only empirical data that exist to evaluate change for some group members. There are problems with the reliability of data in records, particularly if multiple practitioners wrote the records. However, practitioners and researchers should not neglect this relatively easily obtained source of data.

Research indicates that group workers (Chapman, 2010), as well as other clinicians (Hannan et al., 2005) have difficulty making accurate predictions of client outcomes without the aid of systematic measures. In addition, there is evidence that monitoring (i.e. measuring) treatment outcomes can not only reduce adverse outcomes but also prevent deterioration (Burlingame, Fuhrman, & Johnson, 2004; Kazdin, 2005; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005). Systematic and ongoing measurement provides the group worker with the opportunity to readjust interventions should the data indicate changes are needed (Hannan et al., 2005).

Measures of Group Process

Measures of group process are designed to illuminate what is occurring within the group and to identify and assess the factors that are necessary for the functioning of an effective small group. A number of variables have been identified in the literature as belonging to the phenomenon of group process, but no one constellation of variables has received universal acceptance. Thus each measure of group process described in this section constitutes a slightly different subset of group process variables. Furthermore, a definitive list of group processes is probably not possible, given that group processes are influenced by the group work approach, by the stage of the group's development, by forces outside of the group, and by individual differences within the group.

A number of different tools have been developed to measure group processes or, more generally, group conditions. The tools discussed here were selected based on the following criteria: (1) their use has been discussed in peer-reviewed professional literature; (2) they have utility for both researchers and practitioners; (3) they are relatively low in cost and require little training to use. The reader is also referred to the book by Beck and Lewis (2000) that offers a comprehensive review of nine approaches developed over the past 50 years to study small groups. The systems of analysis presented focus on observations of group interaction from a psychodynamic perspective. Two of the instruments presented

by Beck and Lewis, which may be of most interest to readers of this chapter, are the Hill Interaction Matrix (HIM) and the Individual Group Member Interpersonal Process Scale (IGIPS). Readers are also referred to the annotated review of 26 group process instruments by Fuhrman and Packard (1986).

Perhaps the most widely known conceptualization of group process is Yalom's (1995) therapeutic factors. To empirically explore these 12 therapeutic factors, which were developed based on his and others' experience with group psychotherapy, Yalom developed 60 statements, 5 for each of the 12 therapeutic factors. Patients, and in some cases group psychotherapists, were asked to perform a Q-sort on these 60 statements using seven categories, from "most helpful" to "least helpful." The original Q-sort has been replaced by a self-administered checklist, on which Yalom's 60 statements are ranked on a 4-point Likert scale, with 0 corresponding to "not helpful" and 3 to "very helpful" (Butler & Fuhrman, 1983).

A variety of studies have demonstrated that clients view the presence of these factors as important to their group experience. However, the relative importance assigned to each factor has varied by the group studied. For example, research has consistently shown that cohesion and universality are perceived as important in the group experience of clients in self-help groups (Heil, 1992; Lieberman & Borman, 1979), psychotherapy groups (Bednar & Kaul, 1994), and cancer support groups (Weinberg, Uken, Schmale, & Adamek, 1995).

More than 40 separate studies have reported empirically on the use of the Yalom therapeutic factors questionnaire. Peer-reviewed data on reliability and validity have been published, including a factor analysis of the questionnaire; Yalom (1995) lists references to these in his book (see also Fuhrman, Drescher, Hanson, Henrie, & Rybicki, 1986). A critique of the therapeutic factors questionnaire and an alternative instrument based largely on the same concepts has been offered by MacNair-Semands and Lese (2000). However, this new questionnaire has not been as widely adopted as the original Yalom questionnaire.

Clearly, the advantage of the Yalom therapeutic factors questionnaire is its widespread adoption by both the practice community and researchers. Furthermore, the 60-item questionnaire is relatively easy to administer to adults. One disadvantage of the therapeutic factors questionnaire is that it measures participants' perceptions of the *importance* or *value* of each of the therapeutic factors but not whether the factor was actually present in the group (MacNair-Semands & Lese, 2000).

Another self-report instrument for measuring group conditions, developed by Rudolph Moos, is the Group Environment Scale (GES; Moos, 1986). The GES is a 90-item, true-false instrument. Conceptually, the GES consists of three domains: relationship, personal growth, and system maintenance/system change. Each domain is measured by 1 of the 10 subscales that constitute the GES. In the Relationship domain, subscales measure Cohesion, Leader Support, and Expressiveness. The Personal Growth domain is measured by the Independence, Task Orientation, Self-Discovery, and Anger/Aggression subscales. The System Maintenance/System Change domain is measured by the Order and Organization, Leader Control, and Innovation subscales. The manual for the GES contains a conceptual and operational definition for each of the subscales, as well as normative data from 148 groups. The normative data are further broken down by type of group: task-oriented, social-recreational, and psychotherapy/mutual-support groups. Data are provided on the reliability and validity of the scale. Finally, the manual for the GES contains references to more than 25 studies that have used one or more of the subscales.

Unlike Yalom's therapeutic factors questionnaire, which grew out of practitioners' experiences, the GES's development was guided by the application of systematic psychometric

methods. Although the GES has been used with a wide variety of groups, from committees to support and psychotherapy groups, most of the current research appears to be focused on task-oriented groups and is found in the organizational management literature.

A number of relatively simple methods for collecting data on group conditions have been suggested by Rose (1984). Relevant to the discussion of tests and checklists, Rose proposed the use of a postsession questionnaire (PSQ) administered at the end of every group session. The questionnaire collects both qualitative and quantitative data on group member's perceptions of the usefulness of the group, satisfaction with the group, cohesion, and self-disclosure. There are no published data on the reliability or validity of the PSQ, and no norms exist; thus the PSQ should be used ideographically. Although the postsession questionnaire has been used in a variety of studies by Rose and his colleagues (e.g., Magen & Rose, 1994; Rose & Edleson, 1987; Whitney & Rose, 1989), as well as by others (e.g., Anthony & O'Brien, 2002), its utility is as a simple, easy-to-use tool for practitioners.

A qualitative instrument for collecting data on group conditions is the critical incident report. Like the postsession questionnaire, the critical incident methodology asks group members at the end of a group session to:

Please describe briefly the event that was most personally important to you during today's session. This might be something that involved you directly, or something that happened between other members, but made you think about yourself. Explain what it was about the event that made it important for you personally. (MacKenzie, 1987, p. 31)

MacKenzie (1987) had clinicians categorize the critical incidents into categories that roughly corresponded to Yalom's therapeutic factors. A similar critical incident methodology, but one with a different conceptual coding system, has been used in the study of task group behavior (see, e.g., Taggar & Brown, 2001). The advantage of the critical incident report is that group members' words are not filtered through preconceived questions or limited to specific response categories. A disadvantage of this approach is that participants must possess the cognitive and writing skills to clearly explain the critical incident.

An instrument developed by Macgowan (2000) is the Groupwork Engagement Measure (GEM). In this instrument, engagement is conceptualized as a multidimensional construct across seven dimensions: attendance, contributing, relating to worker, relating with members, contracting, working on own problems, and working on others' problems (Macgowan & Levenson, 2003). The GEM has 37 items scored on a 5-point Likert scale from 1, "rarely or none of the time," to 5, "most or all of the time." Macgowan has subjected the GEM to tests of validity and reliability with various populations and types of groups (see also Macgowan, 1997). The GEM is a relatively short instrument, which makes it easy to use both in practice and research. There is a growing body of evidence to support the psychometric properties of this instrument. Furthermore, the multidimensional construct of engagement emerges both from practice with groups and from research on group conditions.

The Clinical Outcome Results Standardized Measures (CORE-R) battery (Strauss, Burlingame, & Bormann, 2008) is a toolkit of measures promoted by the American Group Psychotherapy Association (AGPA). The CORE-R measures are grouped into three categories, each of which contains multiple measures: group selection and pregroup preparation measures, process measures, and outcome measures. The group selection and pregroup preparation category has two self-report instruments, the group therapy questionnaire and the group selection questionnaire, which are designed to aid group workers in making decisions about group composition. Six instruments are included in the CORE-R's group

process section: Working Alliance Inventory, Empathy Scale, Group Climate Questionnaire, Cohesiveness scale of the Therapeutic Factors, and the Critical Incidents Questionnaire (discussed earlier). The outcome portion of the CORE-R has three scales—Target Complaints, the Rosenberg Self-Esteem Scale, and the Inventory of Interpersonal Problems—and the Outcome Questionnaire 45. An advantage of the CORE-R is that instruments were selected using criteria that included being psychometrically sound, short, and easy to use. In addition, the advocacy of the AGPA may mean that these instruments will become widely used.

Rose (1984) also suggests several easy-to-implement observational coding systems for use in groups. A simple measure, attendance, is logically related to outcome, although, as Feldman, Caplinger, and Wodarski (1983) indicated, group members who drop out, who successfully complete treatment, and who unsuccessfully complete treatment are three distinct groups. Similarly, records of promptness to group sessions can be used to measure time in the group. The marketing wisdom that people vote with their feet also applies to groups; these simple measures of attendance and promptness can indicate to what degree people are voting with their feet.

Observational measures of participation in the group can be as straightforward as tally marks to record the frequency of group member participation. Rose (1984) recommends recording who in the group is speaking every 10 seconds. Somewhat more complex observational systems record the patterns of speaking, such as whether members are addressing the group, the leader, or one particular member. These measures of participation, much easier to learn and use than other observational systems such as the HIM, systematize what many group leaders and researchers treat as anecdotal data.

FUTURE DIRECTIONS

The knowledge and tools to measure outcomes for members participating in groups have advanced, both in the research and in the practice arenas. Although a number of tools exist for assessing group processes, they have not been subjected to the same rigorous use or testing as measures of outcome. The larger problem, however, is that the conceptual definitions of group conditions are still amorphous. Progress has been made; for example, Bonito (2002) tackled the methodological and conceptual issues involved in understanding and analyzing participation in groups. This is a good first step for one of the multitude of variables that have been identified as relevant to understanding groups. Researchers too often conduct rigorous studies in which a group is the context for the intervention, but no measures are made of the group condition. This ignores both the context of the intervention and the possible confounding nature of group variables on outcome. Finally, the relatively new and complex statistical techniques for analyzing nonlinear and dependent data offer another avenue for understanding the multiple relationships with groups, as well as the connections between process and outcome. While these statistical techniques offer researchers tools for analysis, their complexity may create a further divide between research and practice.

The *Oxford English Dictionary* (2003; <http://dictionary.oed.com>) lists one of the earliest uses of the word *measurement* in the 17th century. One of the definitions is “a magnitude, quantity, or extent calculated by the application of an instrument or device marked in standard units.” This chapter has discussed the instruments as applied to groups. Measurement need not be a complex undertaking, but it needs to be systematic, with a set of associated standards. Measurement is necessary for understanding what is occurring in groups and with group members. The choice is what to measure and how, not whether to measure.

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CHAPTER 31

Qualitative Research

SUSAN PRESTON
JUDY HUGHES
MICHAEL R. WOODFORD

Group work is a unique site of social work practice, in which social workers as facilitators engage group members to work together through process and content. Group work has been part of social work for over 100 years, beginning with the settlement house movement (Dominelli, 2008). More recently, in the neoliberal climate, group work has been posited as an effective and efficient means of meeting the needs of a large number of clients (Mayadas, Smith, & Elliott, 2004; McCrone et al., 2005). Concurrently, there has been a shift toward evidence-based practice in social work, raising expectations for social workers to incorporate research into practice and create new knowledge (McNeece & Thyer, 2004; Rosen, 2003). Both qualitative and quantitative research are useful with respect to group practice. However, in understanding group practice, qualitative methods are especially appropriate for documenting group content, the processes and interactions that occur within groups, and the facilitators' interventions, all of which contribute to effective outcomes. In this chapter, we put forward qualitative research as a valuable and rigorous form of social inquiry that is well aligned with group work and as something we encourage both beginning and seasoned group practitioners and researchers to employ. To this end, we begin by focusing on the context of research in social work practice today. We then shift to discuss steps for engaging in qualitative research regarding group work.

EVIDENCE-BASED PRACTICE AS A PROFESSIONAL OBLIGATION

To effectively meet clients' needs, social workers are expected to use research to inform their practice (Canadian Association of Social Workers [CASW], 2005; National Association of Social Workers [NASW], 2008). They also are expected to engage in research in order to strengthen the profession's knowledge base and thus its integrity (CASW, 2005; NASW,

2008). Consistent with these obligations, the Association for the Advancement of Social Work with Groups (AASGW) offers the document *Standards for Social Work Practice with Groups* (2010), which includes standards that specify that “practice should be based on currently available knowledge and research” (p. 5) and “the worker should have a commitment to supporting research on group work and to disseminating knowledge about effective practices” (p. 6). These obligations in turn promote competence by encouraging social workers to use the results of existing research in their group work practice, as well as documenting and disseminating findings about the groups they facilitate.

Alongside other human service professions, social work has taken up the practice of seeking, evaluating, and applying knowledge to inform practice. The empirical knowledge available often comes from psychology and health disciplines with a longer tradition of research practice than social work. Yet social work is its own discipline, with its own foundation of skills, values, and practices that, if documented and published, would strengthen that knowledge base. Moreover, funders and other oversight organizations are increasingly expecting social service agencies to provide evidence of the success of their interventions, often through forms of program evaluation (Raines, 2004; Steinberg & Luce, 2005). Given the need for profession-specific knowledge and external expectations regarding the evaluation of service outcomes, it is imperative that social work enhance its current knowledge base through empirical inquiry. The evidence-based practice movement within social work has taken up this charge, which has also been applied to group work.

As a forefinder of evidence-based group work, Pollio (2003) argued that building and integrating knowledge into group work practice is an ethical necessity. Evidence-based group work is intended to identify and assess measurable indicators of the process, content, and outcomes of groups, and, like other forms of evidence-based practice, it incorporates both scientific and practice knowledge (Macgowan, 2008). However, Malekoff, citing Gitelman and Knight's (2013) “evidence-guided practice” (Malekoff, 2014, p. 35), argues that using evidence to *guide* group work practice is a better fit, as it is more attentive to context than current forms of evidence-based practice and counters the risk of evidence-based practice formulating standardized techniques that may ignore the art and heart of group work (Steinberg, 2006). Following this approach, evidence-guided practice aligns with group work's valuing of insider knowledge, such as appreciating social workers' practice wisdom and valuing group members' knowledge, both being valuable as lived experience and insider knowledge.

CURRENT RESEARCH REGARDING SOCIAL WORK WITH GROUPS

In preparing this chapter, in order to help the reader understand the context of social work research specifically concerning group work practice, we conducted a content analysis of articles published in the journal *Social Work with Groups*, from 2009 to the most recent issue at the time of writing the chapter (Winter 2015). Of the 201 articles published in this period, we found 54 empirically based articles, of which 23 used qualitative methods. Of these, the majority used general qualitative interviews or focus groups, while five employed grounded theory methodology, two were case studies, and one used an ethnographic methodology (see Table 31.1 for a description of these methodologies). The majority of the articles we reviewed were conceptual or descriptive, depicting the development of a diversity of groups, including rationales for their development, descriptions of the group structure and composition, and how these are implemented in particular organizational or agency contexts, as well as

group session information and theoretical frameworks. Other articles offered clinical case examples of interactions that occur between participants or participants and facilitators to illustrate the use and impact of particular practice skills. Examples are Miller and Mason's (2012) account of how group cohesion is maintained in an open-ended group treatment program for youth experiencing mental illness and Hall's (2011) outline of practice techniques and skills used in a domestic violence group for men. Although nonempirical articles are insightful, to build the profession's knowledge base, empirical studies are critical.

Though from different epistemological stances (Bamberger, Rugh, & Mabry, 2011), both quantitative and qualitative evaluation provide the ability to measure outcomes (Shaw, 2003) and answer the question: Is the group successful or effective? However, only qualitative methods can provide evidence from the context of the group itself to describe what makes that particular group effective. For example, in using mixed methods to study court-ordered male clients' engagement in a domestic violence treatment group, Chovanec (2012) qualitatively interviewed four facilitators and eight male participants from the group and quantitatively assessed engagement among 95 male participants. Although the quantitative results showed that the engagement of these clients increased over time, it was through the use of qualitative interviews that Chovanec was able to assert that engagement occurred as the men began to listen to each other without interruption and learned from the stories of other men within the group. As another illustration, Olson-McBride and Page (2012) used analysis of videotaped group sessions with 18 group participants to describe how music lyrics were used in a therapeutic group for high-risk youth. These researchers reported that the themes from the songs chosen by the group members provided a safe and neutral point at which to begin discussion of the lyrics, which then shifted to the sharing of feelings and experiences. In a final example, Rocke (2015) employed grounded theory to explore the effectiveness and impact of humor as a specific practice technique in antiracism groups. Through her analysis, Rocke demonstrated that humor was used repeatedly throughout the group process, as the group facilitators utilized self-deprecating humor to put participants at ease and gentle teasing to expose and explore the use of discriminatory remarks made by participants during the group sessions.

Our content analysis, though limited to one journal, corroborates what others have observed (Macgowan, 2008; Reid & Fortune, 2003; Trevithick, 2005); that is, while there is some evidence of research being used to study various aspects of group work, additional social work research on group work is needed. Research in this field may be growing, yet anxiety and fear about doing research and a lack of research capacity among some group workers (Lorenz, 2004; Orme & Powell, 2008) are significant challenges. Qualitative inquiry may be an effective entry point for social workers to conduct practice-related research, especially given similarities between social work practice and qualitative research (Epstein, 1988). We suggest that undertaking qualitative research on social work groups is one way that social workers can contribute to the group work practice knowledge base.

WHAT QUALITATIVE RESEARCH CAN OFFER US

Some scholars view quantitative inquiry, especially when assessing intervention efficacy, as the only rigorous source of evidence for practice, whereas others distinguish between quantitative inquiry as primary research and qualitative inquiry (and other forms of knowledge) as secondary research (e.g., Johnson & Austin, 2008). Some continue to promote quantitative research as the gold standard of evidence-based practice, especially through

the use of randomized controlled trials, whereas others acknowledge the usefulness of both quantitative and qualitative research (e.g., Curry, Nembhard, & Bradley, 2009; Magill, 2006; Nastasi & Schensul, 2005). There appears to be no common agreement on the type of evidence necessary for examining the effectiveness of social work interventions, nor specifically for group work. We recognize the value of quantitative research for guiding social work practice with groups through the use of larger sample sizes, standardized measures, and the ability to generalize findings. However, we also believe that qualitative research offers equal although different benefits, including rich descriptions of the localized complexities and dynamic processes that occur within social work groups. Furthermore, as the findings documented through qualitative research describe the context and processes of groups, this approach to research can provide a form of practical or actionable evidence that can be readily used in practice, which may help narrow the research–practice gap (Sandelowski, 2004). Moreover, qualitative research shares a synergy with group work, wherein principles of qualitative research focused on complexities, processes, participant knowledge, and deep understandings align well with the values and practices of social work with groups.

Recognizing that evidence-based practice is and will continue to be an expectation for most human services, building capacity for conducting qualitative research is vital to advancing evidence-guided group work practice. In the remainder of this chapter, we describe the general process of conducting qualitative research, whereby we hope to encourage social workers and early-stage researchers to engage in empirical inquiry about group work practice.

ENGAGING IN QUALITATIVE RESEARCH FOR SOCIAL WORK WITH GROUPS

Depending on the research question, one might conduct a quantitative, qualitative, or mixed-methods study (Creswell, 2013); our focus is on qualitative inquiry. All studies tend to unfold in a mixture of linear and iterative ways, yet qualitative research is often more flexible than quantitative research. Qualitative studies are shaped by the study context and tend to adopt an evolving design (Creswell, 2013; Padgett, 2008) based on experience and emerging data, rather than a predetermined research design. In other words, a qualitative study, especially one located in the interpretive paradigm, leaves room within the design for changes in data sources, in how the data are collected, and in new questions to be posed. In this way, the design of a qualitative research study is similar to planning a group; there is an overall goal, with specific intended outcomes, and an outline of how the group will work toward those outcomes, yet the group's evolving process may mean the initial plan is changed. In some ways, this flexibility within qualitative research is consistent with the fluidity of group work practice as a messy process (Malekoff, 2014).

Foundations of Research Design

In considering qualitative research for group work, there are a rich variety of methodologies and methods from which to choose. In our content analysis, we found that the majority of qualitative studies took a more generalist approach, using either interviews or focus groups rather than following a specific qualitative methodology such as grounded theory, case study, narrative inquiry, ethnography, or phenomenology. One strength of the generalist

approach is that it allows flexibility in the choice of data collection and analysis methods. Similar to group work, in which the content and process are integrated and iterative and in which the process emerges based on the experience, the flexibility of a generalist qualitative approach is appropriate. This variability also creates space for seasoned practitioner/researchers to employ emerging methods such as arts-based research.

The more specific methodologies noted above have strengths in providing practitioner/researchers, especially those who are novice researchers, with specific guidance on how to design a study. Furthermore, because these methodologies are accepted and respected methods of doing research, their use can lend credibility to a project. For readers who are interested, Creswell (2013) provides descriptions of these five methodologies, whereas others review various forms of arts-based approaches as an emerging qualitative tradition (Knowles & Cole, 2008). In discussing steps in the research process below, we acknowledge that many aspects of the research process are similar across all qualitative approaches, and we highlight these similarities as we review common steps of the research process and discuss their application to studying social work groups. We also draw on examples and ideas specific to the five common methodologies, knowing those examples also can inform a more generalist approach to qualitative research. These five methodologies are briefly described in Table 31.1.

TABLE 31.1. Methodologies of Qualitative Research

Description	Method
<u>Case study</u>	
A case study is an examination of a particular case that is a bounded system (e.g., a particular group intervention or setting) in order to develop an in-depth understanding of the chosen case.	Researchers engage in a variety of forms of data collection, including interviews and documents.
<u>Ethnography</u>	
Ethnography involves spending time with a particular group in order to document shared patterns of beliefs, language, behaviors, and values.	Researchers generally use interviews and observations.
<u>Grounded theory</u>	
Grounded theory is a process of inquiry seeking an explanation of an experience.	Researchers often conduct interviews, but may also utilize other forms of data collection.
<u>Narrative inquiry</u>	
Narrative inquiries are used to study how individuals construct meaning about their identities, events, and/or experiences, such as participation in a group intervention.	Researchers usually collect stories through interviews.
<u>Phenomenology</u>	
Phenomenology seeks the common meaning or essence of a lived experience for a group of individuals and is focused on a description of the phenomenon or experience, for example, leading clinical groups with a particular population.	Researchers commonly employ a long interview method.

Note. Based on Creswell (2013).

Rigor

As part of the research design process, researchers must attend to rigor. In qualitative inquiry, rigor is concerned with the authenticity and trustworthiness of the findings (Erlandson, Harris, Skipper, & Allen, 1993). Faithful representation of the participants' experiences and attentiveness to the potential implications of the research are important for establishing authenticity (James, 2008). Qualitative research methodologists have evolved the use of established techniques to minimize researcher and participant biases and reactivity, all of which are threats to trustworthiness (see, e.g., Erlandson et al., 1993; Lincoln & Guba, 1985; Padgett, 2008). Trustworthiness focuses on the study's methodological soundness and its truth value, which involves each of the following four characteristics—credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985)—which can be supported through various tactics, as outlined in Table 31.2.

TABLE 31.2. Tactics to Foster Rigor

Prolonged engagement

The researchers' past experiences in the field and relationships with stakeholders can foster trusting relationships with participants, which is helpful in addressing reactivity and participant bias and also can foster the researchers' increased sensitivity to emerging concepts.^{a,b,c}

Triangulation

Having more than one researcher, collecting data from multiple sources representing various perspectives, combining different data collection tactics, and/or using various theories to understand the data can help to reduce each threat to rigor.^{a,b}

Peer debriefing

Consulting colleagues about emerging findings is useful in obtaining another perspective about one's interpretations, while also getting other ideas, both of which are useful in minimizing research bias.^c

Member checking

Themes and analyses are presented to participants and/or other key stakeholders in order to verify one's interpretations.^{a,c} This strategy can occur within an interview or following data analysis and interpretation.^a

Negative case analysis

Inclusion of data that contradicts themes identified in the data helps to address researcher bias.^c

Audit trail

Documenting methodological and self-reflective memos can help to reduce researcher bias.^c

Thick description

Providing rich details about how the study was conducted, the research context, and the data (through the provision of quotations) can reduce researcher bias and promote transferability.^a

^aSee Erlandson et al. (1993).

^bSee McCracken (1988).

^cSee Padgett (2008).

Credibility, speaking to the accuracy of the findings from the stance of important stakeholders, is concerned with the ability of the research process to produce findings that are accurate in understanding the depth and scope of the issues under study. Tactics to enhance credibility include prolonged engagement, peer debriefing/support, and member checking. *Dependability* deals with data collection, analysis, and interpretation procedures and emphasizes transparency in terms of outlining one's reasoning for methodological decisions. An audit trail is one way to promote dependability. *Confirmability* refers to the ability to determine the reasonableness of the inferences and logic of the themes and other findings that evolved from the data. For example, are the findings linked to the data rather than the researchers' reflections? Are all voices, including disconfirming perspectives, represented in the findings? To enhance the confirmability of a qualitative study, a researcher can use quotations from many participants, identify the number of participants who endorsed a particular theme, incorporate triangulation, and employ negative case analysis. *Transferability* involves consideration of how useful a tentative application of findings might be in other environments. Thick description and audit trail are two of the tactics that can promote transferability.

In qualitative research regarding group work, researchers make choices about which tactics of rigor will best enhance the trustworthiness of their study and incorporate those tactics into their research design. In their case study of youth engagement with inter-group dialogues, Richards-Schuster and Aldana (2013) used participants' quotations and researcher memos to develop and refine their themes and member-checked their findings with participants to foster truth value. To promote confirmability in a grounded theory study regarding interdisciplinary cofacilitation of groups, Banach and Couse (2012) engaged in data triangulation by analyzing both the group cofacilitators' notes from each session and the transcripts of a focus group with all cofacilitators after the therapy groups ended.

Having discussed the foundational elements of research design, we now turn our attention to various components of research design, namely problem formulation, data collection, data analysis and interpretation, and knowledge mobilization and dissemination.

Components of Research Design

Problem Formulation

The research process begins by identifying a topic of interest, a specific research problem that needs to be explored, and a purpose for the study. Research purposes may be exploratory, descriptive, or explanatory (Rubin & Babbie, 2013), though qualitative research most commonly is exploratory or descriptive. These broad purposes then are developed into a list of specific research questions or objectives (Creswell, 2013; Rubin & Babbie, 2013). As part of that process, researchers consider what epistemological paradigms, theories, and world-views, as well as current research, inform the research problem, purpose, and question and the feasibility of the research being proposed. When considering the research question and purpose, given the applied nature of social work research, researchers should be clear on the relevance and value of the proposed study for informing social work practice. Researchers also need to explore the existing knowledge on the topic, which can help refine the research question and clarify concepts, as well as understand factors relevant to research design.

Designing a study entails determining how one intends to address the research question and aims. Although this begins with the research question, research design is influenced by various factors, including one's theoretical/conceptual framework, personal experience with

the topic, and capacity to engage in particular forms of inquiry, as well as ethics and study feasibility (Gibbs, 2001; Rubin & Babbie, 2013). A literature review is the foundation for any research or evaluation project (Holosko, 2006). In examining the literature, in addition to identifying gaps in the knowledge base, researchers systematically explore how similar research questions have been answered and what issues arose in seeking those answers. In doing so, researchers seek substantive, theoretical, and methodological content relevant to their topic. Substantively, one might consider who has studied the topic, the contexts in which it has been studied, the group or population, and what has been studied (and not studied). Theoretically, one might consider what paradigms and theories have informed existing research. In doing so, researchers question whether there is a particular theoretical understanding that is a “good fit” with the substantive topic (e.g., feminist theory might have a good fit with research about/with women) and how the review of theory might inform and be informed by the researcher’s emerging conceptual framework. Methodologically, researchers might focus on “how” the topic has been studied. Has it been studied quantitatively, qualitatively, or with mixed methods? Within these approaches, which particular methodological traditions have been used (e.g., in qualitative research, narrative, grounded theory or something else) and what data collection methods have been used (e.g., interviews, focus groups)? For example, Poole, Gardner, Flower, and Cooper (2009) note that although narrative therapy is often used with individuals and groups, there is a lack of research on narrative therapy and group work; this gap is part of the rationale underpinning their study and research question: “What do older group participants coping with mental health and substance misuse issues find helpful (or not) about narrative therapy?” (p. 291). In another example, Coholic, Loughheed, and Lebreton (2009) state that, although there is a growing number of social workers who are committed to newer approaches to spirituality and the use of expressive and creative arts in practice, little research has explored the use of these methods in group work practice with children in foster care. These researchers state that they undertook their grounded theory study of 15 six-week children’s groups to document how these newer group work practice approaches are used and can be improvised to work with children who have experienced trauma (Coholic et al., 2009). We note that in group work research, problem formulation can focus on “problem-related outcomes” that are related to group content/purpose, “group-related outcomes” that concern group process, or both (Macgowan, 2008, p. 4), and in this way it asserts that outcome research can attend to both content and process. As an example, Poole and colleagues (2009) use an ethnographic inquiry approach to study both content and process regarding narrative therapy group work. We also maintain that qualitative research is useful for documenting outcomes of group work practice. For example, McGuire (2004) used individual interviews to assess self-sufficiency outcomes as an evaluation of a women’s group.

Data Collection

In designing their studies, qualitative researchers give careful consideration to: (1) who (e.g., group participants and facilitators) or what (e.g., documents, photographs, videotapes of group session) will be in the sample and then (2) how the information will be collected (e.g., interviews, observation, focus groups). Qualitative researchers tend to utilize purposive sampling, in that participants and other data sources are selected because they are able to contribute to the research aims (Creswell, 2013), with a general aim to be inclusive of diverse perspectives. For example, in a study of the value of group work with older adults, Lee and Ayón (2006) sought specifically to interview group members from various cultural groups

to promote understanding of the similarities and differences in group work experiences of these different group members. Similarly, when using group interviews, researchers must think very carefully about the composition of the focus groups, as participants will not only answer particular questions or speak to their own experiences but will interact with each other and possibly alter their own responses based on those of others in the group. Researchers need to decide what particular mix of identity characteristics (e.g., gender, race, class, sexual orientation) and perspectives (e.g., participants, facilitators) will enhance or stifle interaction when focus groups are conducted.

Along with determining the appropriate sample, researchers consider what method(s) of data collection best suit their research question. Based on the particular research design, qualitative data can be collected in many forms, including personal or group interviews (using highly structured to unstructured designs), observation, and documents, as well as a variety of emerging arts-based methods (Chonody, 2014). Interviews, both individual and group, were the most common method of data collection in the articles we reviewed and fit well across all five of the qualitative inquiry approaches (Creswell, 2013). Ma, Wong, Wan, and Wong (2011) used in-depth interviews with open-ended questions to ask family members about their experience after completing a family-focused group. This study used a practice of family interviewing, which could be considered a group interview method somewhere between individual and focus group interviews. In making this choice, the researchers opted for a method that provides rich data about the interactions that occur as people are brought together in groups. As a design choice, some researchers use individual interviews to obtain in-depth lived experiences, along with focus groups, to understand how meaning is constructed in groups.

When examining interactions, existing documents, or generated materials such as photographs or videos, group work researchers must decide what it is they are exploring in these materials. For example, if a researcher wants to observe the interaction in particular therapeutic groups or ask research participants to generate photographs about their experiences of being in the group, then the researcher must have a sense of what interactions or what aspects of the photographs might be important in addressing the research question. Macgowan (2010) and Cohen (2010) both used forms of textual analysis to examine student assignments as part of studies exploring student experiences in group work practicum settings (Macgowan, 2010) and completing experiential assignments in a group work course (Cohen, 2010). Macgowan searched for descriptions of what actions the students took in their groups and their reflections on those actions, regarding their efforts to incorporate evidence-based group work into their practicum. Cohen focused on students' experiences of group conflict, development, roles, and leadership as members of a task group. In both studies, the researchers were clear about what they were exploring in the data that were generated.

Data Analysis

Generally, qualitative research projects are iterative, with data collection and analysis ongoing and overlapping (Pope, Ziebland, & Mays, 2000), allowing the researcher continued opportunities to refine the research questions and dig deeper into emerging areas of interest as data are collected. Documenting these decisions and changes is important in fostering the study's rigor. In analyzing qualitative data (e.g., interview transcripts, observation field notes, documents, or arts-based material), researchers commonly move through the data, placing relevant parts of the data into conceptually similar containers, called codes. Each

code has corresponding data (e.g., words or lines from a transcript) captured within it. These codes, which should be conceptually distinct, are then given names and descriptions. In group work research, and stemming from the research questions, codes may be related to factors such as group roles or stages of development or processes such as mutual aid or member-with-member interaction.

There are many decisions that go into the choosing of codes and related pieces of text. When generating codes, some researchers start with *a priori* codes (e.g., derived from theory or existing research), whereas others create and name codes as they emerge from the data. The data captured within a code can range from smaller pieces of text (e.g., words, sentences, or partial images) to larger chunks of data (e.g., paragraphs, whole documents, or photographs; Anastas & MacDonald, 1994). Codes can be chosen that represent the directly stated meanings within the data, or they can represent latent or hidden meanings (Creswell, 2013). Generally, codes are tentative at first but then become refined and firmer as the analysis process continues. Given the complexity of communication, one piece of text can conceivably fit within several codes (Padgett, 2008). Codes can also be combined or merged with one another, or one large code can be broken down into smaller, more precise codes. Codes may be freestanding lists of themes, or they may be clustered into groups of similar codes in a hierarchical arrangement (Creswell, 2013; Padgett, 2008).

The amount of coding and how various research materials are brought together is dependent upon the particular qualitative tradition used by the researcher. In a grounded theory study, codes and coding processes have a central feature. Grounded theorists begin with line-by-line coding that builds up until these researchers have a list of abstracted codes and a central core category is identified. For example, in a grounded theory study testing a psychoeducational model of group work for family caregivers, Lee and Yim (2013) conducted data analysis of focus group data using a multistaged coding process:

(1) open coding, assigning initial codes in a first attempt to condense the large data set into categories; (2) axial coding, looking for concepts that gather together and investigating associations between evidence and concepts; and (3) selective coding, looking selectively for cases that exemplify themes and making comparisons/contrasts. (Strauss, 1987, p. 19)

Member checks, in which the emerging grounded theory is provided to participants, are used to verify the theory that emerged from the researcher's coding procedures (Strauss & Corbin, 1990). Banach and Couse (2012) provide an example of this in their study of multidisciplinary cofacilitation of groups, in which they reviewed their findings and conclusions with participants.

Researchers using different methodologies, such as case studies and ethnographies, also rely on coding, although the focus is not on these procedures but on how they bring together data from various sources, including observations, interviews, and documents, to provide a thick description of the setting or case being described (Stake, 1995). Richards-Schuster and Aldana (2013) used *a priori* coding to analyze data from individual and group interviews, as well as program materials, in their case study of youth engagement with intergroup dialogues. Poole and colleagues (2009) used inductive multistage coding to analyze field notes and interview transcripts in their ethnography of narrative therapy group work. In a case study of an online support community for parents whose children committed suicide, Jones and Meier (2011) used content and thematic analytical coding of emails, website forums, and community documents, such as newsletters and orientation materials.

Interpreting the Findings

In interpreting their data, qualitative researchers both describe and make inferences and conclusions from the data. Sandelowski (2004) distinguishes between the data-based view and the empirical/analytical view of qualitative data analysis. With a data-based view, researchers attempt to convey the meaning of participants' experiences as closely as possible to the raw data, with findings remaining indistinguishable from the data. However, although still grounded in the data, those findings following the empirical/analytical view are distinguishable from this raw data, as these are the conclusions or inferences that the researcher draws on the basis of a close examination of the data (Sandelowski, 2004).

Different qualitative methodologies may be a better fit with one or the other view of data interpretation. For instance, researchers using case study methods and grounded theory generally follow the empirical/analytical view. The findings from a grounded theory study are typically a list of open, axial, and selective codes illustrated with quotations. The focus, however, is not on these codes but on the theory that is derived through these coding processes. In Lee and Yim's (2013) study of psychoeducational groups for family caregivers, they begin their interpretation by noting main themes from the data analysis and providing a few key quotations to illustrate the themes; then, through their interpretation, they propose specific attributes as recommendations for future psychoeducational groups. Although case studies differ from grounded theories, these methods are similar in offering a new conceptualization of the patterns or themes that describe the uniqueness of a single case or variation among numerous cases (Stake, 1995). In the Jones and Meier (2011) case study, a conceptual map of "member empowerment and boundary spanning" (p. 117) emerged as an interpretation of an online support group organization for parents who had experienced a child's suicide.

In order for the knowledge claims put forward by qualitative researchers to be taken seriously, researchers must make a persuasive case that the final condensed accounts of their findings represent the diversity and complexity of individual and idiosyncratic experiences that were captured in the initial data (Polkinghorne, 2007). This involves a constant negotiation between the small and big pictures of the findings, perhaps similar to a group worker's negotiation between individual and whole-group needs. The interpretation of the group phenomenon needs to balance the individual and the group experience, as well as participants' being "involved in a creative process of meaning making and conversation with themselves" (Davies, 2015, p. 34).

Writing Up and Disseminating the Findings

Disseminating one's findings is critical to improving group practice. Dissemination can occur through written documents, such as full-length reports, participant and stakeholder reports, and journal articles, as well as through community and professional presentations, documentaries, and art exhibits and related modes if the study utilized arts-based methods. When selecting dissemination methods, researchers must carefully consider the various audiences with whom one's findings will be shared (Caulley, 2008; Drisko, 2005; Sandelowski & Leeman, 2012). Primary audiences include the study participants, other group members who did not participate in the study, and other colleagues at the agency sponsoring the group; the organization that funded the group or the research and other group practitioners within one's professional network are secondary audiences. Typically, the presentations

and reports provided to these stakeholders contain lay language and highlight the data and findings in reader-friendly ways, and they can be disseminated on agency websites or other media consistent with the organization's communication strategies. Another important audience is academic researchers and practitioners beyond one's network. Dissemination in academic journals provides the opportunity for other researchers and practitioners to use the findings to inform their work.

Various guidelines for developing qualitative research reports are available (e.g., Drisko, 2005; Sandelowski & Leeman, 2012; Wolcott, 2008). We primarily draw on Drisko's (2005) article to present key considerations. He focuses on traditional research reports; however, we believe his principles are applicable to all forms of dissemination, although some adjustments may be necessary given the intended audience. Drisko reminds researchers that the report, beyond being well written and audience focused, "must always tell the story of the project, richly convey the views of others [i.e., participants], and detail implications" (2005, p. 589). To do so, among other important suggestions, he recommends that a qualitative research report (like the study itself) be constructed around the research question. The question (regardless of dissemination form) needs to be clearly stated early in the report and repeated at key points. Furthermore, any broader purposes underlying the study, such as to raise awareness of a particular group intervention (see, e.g., the model of psychoeducational groups proposed by Lee & Yim, 2013), should be stated. Traditional research reports include a literature review that synthesizes related literature, outlines the rationale for the study and its fit with the literature, and presents the conceptual and epistemological frameworks. Poole and colleagues (2009) provide an excellent example in their article reporting the findings of their ethnography about narrative therapy in group work, in which they provide a brief summary of their literature review and refer readers to their earlier publication that provides full details of that literature review.

As indicated earlier, the researcher's transparency concerning the methods used to answer the research question is pivotal when readers assess a study's trustworthiness and authenticity. Therefore, the methods and tactics used to address the research questions must be adequately described, including the rationale for key decisions, especially when utilizing various techniques from numerous methods. The methods should reflect the epistemology guiding the study (Drisko, 2005), and, if a particular qualitative methodology is used, it needs to be described with a discussion of how the methodology relates to the research question. Within this section, data sources, the type of sample, and how it was identified should be described, as well as how data were collected and analyzed, including how codes and categories were created and any particular strategies used to foster the study's rigor (Drisko, 2005).

Qualitative research publications have been critiqued for their lack of detail regarding methods (Anastas, 2004; Zaruba, Toma, & Stark, 1996); indeed, in our content analysis, overall we found such detail was limited, although this could be a reflection of the journal's scope and audience. Empirical articles about group work in research-focused journals (e.g., *Qualitative Social Work*, *Small Group Research*) tend to offer more detail, and hence greater transparency, regarding methods used in the studies. For example, Wheelan, Davidson, and Tilin (2003) offer a detailed description of their sample and data collection methods in their study of group member behavior and perceptions over time. As another illustration, Boddy (2009) provides an extensive narrative of the theoretical framework, methodology, sampling, and data collection methods in their study of a group mentoring program for marginalized women.

Turning to the findings, the data should be central, with presentation of sufficient data to illustrate categories and themes. Drisko (2005) cautions against presenting a single quotation to convey a theme and proposes that multiple illustrations are best to convey richness of the data. Chenail (1995) suggests that researchers use juxtaposition as strategy to write findings, so that “data is star” as the researcher interprets the data in relation to themes, whereas Caulley (2008) notes the value of including sufficient content in a quotation to provide enough detail of a participant’s story. If a study utilizes a particular qualitative methodology, the presentation of the findings must reflect the particular methodology. For instance, if a study is a grounded theory study, the findings should clearly present the theory that is constructed from the data to represent the phenomenon of interest, similar to the model outlined by Lee and Yim (2013).

The final section in most research reports is the discussion. Here, the researcher outlines how the findings relate to the existing literature and the study’s primary contributions and limitations, which commonly inform directions for future research (Drisko, 2005). If there are particular points about the study’s context or the population that, for example, may affect the transferability, these are usually discussed. For example, in a study of interdisciplinary cofacilitation of groups (Banach & Crouse, 2012), future research is recommended using a larger sample and including additional professional disciplines engaged in the cofacilitator role.

Wanting to improve social work, researchers usually outline implications for practice, research, and theory (Drisko, 2005; Sandelowski & Leeman, 2012). In their study of narrative therapy in group work, Poole and colleagues (2009) offer recommendations at the end of their article for integrating practice, research, and theory, including the need for training for narrative-based group work and for finding ways to balance mutual aid with narrative principles, while also calling for further research in these areas. Similarly, Richards-Schuster and Aldana (2013) not only describe how the exercises that are used in their intergroup dialogue programs affect youths’ experiences but also note the ground rules they use to create safety among these youth. In their study of holistic arts-based groups, Coholic and colleagues (2009) combined practical information for future group work practice with children who experienced trauma, including the need for small group sizes and the use of shorter and more concrete activities, with documentation of the impact of specific group activities on the children’s progress.

CONCLUSION

In this chapter, we have explored the usefulness of qualitative inquiry as a means to advance knowledge about group work practice. We began by describing the professional obligations placed on social workers to utilize and undertake research as a means to develop and expand the profession’s knowledge base. We then examined the use of qualitative research in group work through describing the results of a content analysis of articles published in the journal *Social Work with Groups*. Given this context, we recommended the use of qualitative research to understand group work practice and outlined the benefits that qualitative approaches offer for documenting the practices used within groups and how these affect group participants. In the final section, we described common steps in the research process and offered examples of these processes from published research accounts. We hope that this chapter will enable group work practitioners and researchers to engage in rigorous qualitative research as they strengthen the knowledge base concerning group work practice.

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CHAPTER 32

Intervention Research

MARK J. MACGOWAN

This chapter is an overview of intervention research in social work with groups, utilizing a design and development perspective. For clarity, *intervention* is defined as “a purposeful change strategy” (Fraser, Richman, Galinsky, & Day, 2009, p. 184) and is used here broadly to include interventions designed to prevent problems for at-risk populations and reduce or eliminate problems that have become apparent. *Intervention research* is “the design and development of new interventions or fine-tuning existing interventions” (Galinsky & Fraser, 2009, p. 139). *Group work* intervention research typically focuses on changing (1) individual members of a group, (2) subgroups within the group (including the group leader), or (3) properties of the group itself. Sometimes the focus of interventions is on extragroup change; that is, strategies undertaken outside of the group by the worker on behalf of group members (Vinter, 1974). The examples in this chapter relate to (1) and (3), as that is where most intervention research has focused.

Rothman and Thomas (1994) described three facets of applied intervention research: *knowledge development*, *knowledge utilization*, and *design and development*. Intervention *knowledge development* (KD) involves conducting “empirical research to extend knowledge of human behavior relating to human service intervention” (Thomas & Rothman, 1994, p. 3). As it relates to groups, KD seeks to generate research that informs group workers’ understanding of the individuals in the group and the nature of groups, such as group dynamics. Intervention *knowledge utilization* (KU) is “the means which the findings from intervention knowledge development research may be linked to, and utilized in, practical application” (Thomas & Rothman, 1994, p. 3). KU relates to *using* intervention research in practice. One of the models that has been developed to help group workers utilize intervention research in practice is evidence-based group work (Macgowan, 2008). Intervention *design and development* (D & D) is “research directed toward developing innovative interventions” (Thomas & Rothman, 1994, p. 3).

Effective group work incorporates all three, whether it is knowledge from clinical research (KD and D & D) or knowledge obtained through evidence-based group work (KU). Intervention D & D and KU most directly relate to this chapter’s focus on intervention

research. KU in the form of evidence-based group work is briefly discussed, as it has been detailed elsewhere (Macgowan, 2008). Rather, the focus of the chapter is on the D & D process, which will help frame the discussion of the range and issues of intervention research in social work with groups.

The D & D model has been used in a number of intervention development projects (DePanfilis & Herman, 2015; Panzer & Dhuper, 2014), including Making Choices, a program created to help prevent and manage aggression in children (Fraser & Galinsky, 2010). Based on the D & D model, Fraser and colleagues (Fraser & Galinsky, 2010; Fraser et al., 2009) outlined five steps in intervention development: (1) specify problem and program theory; (2) create and revise program materials; (3) refine and confirm program components; (4) assess effectiveness in a variety of settings and circumstances; and (5) disseminate findings and program materials.

This chapter is not a detailed exposition of the D & D process (for that, see Fraser et al., 2009); rather, the steps of the process will be used to illustrate the process of developing and adapting existing interventions for group work, so readers may see the issues, range of interventions, and research methods. In addition, as there is a growing interest in “community-based” interventions and social justice approaches to group research (Garvin, Tolman, & Macgowan, 2016), the discussion is informed by the principles and practices of community-based participatory research. The chapter is for practitioners and beginning researchers who would like an overview of methods and issues in the design and development of group interventions.

THE INTERVENTION RESEARCH PROCESS IN SOCIAL WORK WITH GROUPS

Step 1: Specify the Problem and Develop a Program Theory

The first step involves developing the program theory, which first begins with developing an understanding of the problem or issue. The problem theory helps to inform the program theory. If the intervention is to be developed with a social justice or a strong community perspective, community-based participatory research is often used. The step culminates in an articulation of the problem theory, often using a logic model. These elements are discussed in this section.

Problem Theory

The initial part of this step is a consideration of factors that contribute to an understanding of a problem or issue, which develops a “problem theory.” Defining the problem involves examining not only theories, which may be untested, but also the empirical literature to understand the risk, promotive, and protective factors related to how the problem developed and is sustained (Fraser, 2004). The investigation involves a review of the incidence and prevalence of the problem and attending to particular groups at risk. Developing the problem theory answers both What is the problem? and Why does it exist?, resulting in a putative list of risk, promotive, and protective factors (Fraser et al., 2009). In many cases, the process of investigation reveals mediators, which may become intermediate outcomes in an intervention. For example, in the early development of the Making Choices intervention, Fraser and colleagues (2005) identified social information processing as a mediating factor contributing to aggressive behavior in youth. In the early development of Seeking Safety, a

program designed to help participants manage the co-occurring challenges of alcohol and other drug (AOD) use and trauma, Najavits, Weiss, and Shaw (1997) identified sets of factors related to AOD use and posttraumatic stress disorder (PTSD) among women, such as (1) being overwhelmed by extreme guilt, anxiety, shame, depression, and suicidal feelings; (2) having undeveloped functional skills such as problem solving and relationship skills; and (3) being able to manage AOD relapse.

Program Theory

After the problem theory is defined, a program theory is developed. The program theory is an articulation of the most promising method of addressing the problem, which identifies what malleable factors are to be changed, why group work is the preferred modality, and how the program connects with social work with groups, if developed for social workers.

An important part of the program is the identification of “malleable” factors (Fraser et al., 2009, p. 38) that can be changed, such as interpersonal relationships, rather than static factors that cannot, such as race and SES. For example, Latina adolescents are vulnerable to suicidality, and thus prevention efforts would focus on mother–daughter relational factors, such as mutuality and communication, the lack of which have been identified as risk factors (Zayas, Bright, Álvarez-Sánchez, & Cabassa, 2009).

In addition to focusing on malleable factors, the program theory should justify why *group* work is the preferred modality. Several examples may be cited. Researchers developed a group therapy program to help younger adolescents (10–14 years old) cope with interpersonal weight bias (e.g., teasing, bullying, verbal and physical assaults; Panzer & Dhuper, 2014). The program specifically noted that the group format would be appropriate to help develop peer support, “universalize” (a potentially therapeutic factor in groups) the distress of being a victim, and provide mutual support (Panzer & Dhuper, 2014).

In the beginnings of Seeking Safety, Najavits and colleagues (Najavits, Weiss, & Liese, 1996; Najavits et al., 1997) outlined both how the program attended to the unique malleable factors associated with these problems (noted above) and how group work could be potentially helpful. They noted that the group modality could help build participants’ social support and reach more persons than individual work and that the research evidence to date had indicated that group cognitive-behavioral therapy (CBT) interventions were generally effective.

Another example used small groups to supplement a classroom-based AOD primary prevention program for Mexican-heritage children, “keepin’ it REAL” (kiR; Marsiglia, Peña, Nieri, & Nagoshi, 2010). The “REAL groups” intervention was based on the principles of mutual aid and was added as a supplement to the kiR program as a culturally based secondary prevention program to prevent AOD use among identified high-risk and early AOD using Mexican American adolescents. The group modality was used as it was expected to help “members encourage and challenge each other through mutual aid, resulting in a collective approach to helping” (Marsiglia et al., 2010, p. 105).

If a program is developed for social work, the program theory should also specify how the intervention relates to *social work* with groups. This may be partly addressed in the requirement to include malleable factors, which social workers can attend to, but the program theory should include more. The general aims of social work with groups are to (1) help improve the multidimensional functioning of its members (often using the principles of mutual aid), (2) change the environment (organization, community) to make it more responsive to its members, (3) connect members with needed resources, and/or (4) accomplish a

task external to the group (Garvin, Gutiérrez, & Galinsky, 2004; Northen & Kurland, 2001). Thus, in addition to malleable factors that can be changed through group intervention, the program theory should specify elements or purposes that help achieve these aims through group work. Examples of purposes include group work to enhance interpersonal functioning or social competence or to change social environments to make them more responsive to members' needs.

Another element of the program theory is whether the project needs to include other levels of intervention beyond the group, such as organizations and communities. To be successful, kiR required a strong partnership with organizations and communities, such as Mexican American schools (Marsiglia et al., 2010). To facilitate this, Marsiglia and colleagues utilized community-based participatory research methods, which created a close partnership between residents and researchers from the academic community.

Community-Based Participatory Research

Community-based participatory research (CBPR) “equitably involves community and academic/research partners and integrates the unique strengths that each brings to the research enterprise” (Bermúdez Parsai, Castro, Marsiglia, Harthun, & Valdez, 2011, pp. 34–35). CBPR includes “people who are most affected by community problems as partners at the earliest stage of a project to help define the research goals, to decide how the project will be organized, and to provide their perspective in every aspect of the research process” (Jacobson & Rugeley, 2007, p. 24). CBPR simultaneously addresses the issues of (1) what levels of intervention might be needed (micro or macro), (2) what concerns need to be addressed, and (3) who should be involved. CBPR brings together community partners to answer all these questions.

Bermúdez Parsai and colleagues (2011) have described four phases in the early development of a CBPR—namely (1) evidence gathering and stakeholder involvement, (2) focus groups and initial curriculum, (3) qualitative analyses and curriculum revisions, and (4) lessons learned and planning for the pilot test. The first phase matches this first step of intervention D & D. For example, the need for the REAL groups was first identified by parents and teachers. Both community members and researchers collaborated and “identified significant community needs, and identified the core elements” (Bermúdez Parsai et al., 2011, p. 38). This process not only provided the material for the intervention but also established the collaborative environment needed to create a real community-based group work model.

Schulz and colleagues developed a tool for assessing “equitable working relationships among members” in CBPR (Schulz, Israel, & Lantz, 2003, p. 258). The assessment tool included seven guidelines for creating effective groups in CBPR partnerships (Schulz, Israel, & Lantz, 2004, p. 313):

1. Establish clear, operational, relevant group goals that create positive interdependence and evoke a high level of commitment from every member.
2. Establish effective, two-way communication within which group members communicate their ideas and feelings accurately and clearly.
3. Ensure that leadership and participation are distributed among all group members.
4. Ensure that the use of power is distributed among group members and that patterns of influence vary according to the needs of the group as members strive to achieve their mutual goals.
5. Match decision-making procedures with the needs of the situation.

6. Engage in controversy by disagreeing and challenging each other's conclusions and reasoning, thus promoting creative decision making and problem solving.
7. Face conflicts and resolve them in a constructive way.

Such a tool may be used by researchers to determine how well CBPR processes are being achieved in this first step of CBPR.

Logic Models

Once developed, the program theory identifies the malleable risk and protective factors and link them to program components (Fraser & Galinsky, 2010). Some program developers use logic models, which “links outcomes (both short-and long-term) with program activities/processes and the theoretical assumptions/principles of the program” (W. K. Kellogg Foundation, 2004, p. iii). Whether or not logic models are used, the program theory should clearly articulate the essential core components of the intervention that (1) attend to malleable problem, risk, and/or protective factors, (2) identify levels of interventions, settings, and agents/interventionists (e.g., level of training of group workers needed), and (3) specify program objectives, inputs (e.g., equipment, training), program activities, measurable outputs (e.g., hours of intervention, number of participants), intermediate outcomes (mediators), and/or distal outcomes. For more information and examples of logic models and program theory, see Fraser and colleagues (Fraser et al., 2009) and the Kellogg foundation (2004).

At the end of this first step of the D & D process, there should be a clear program theory that incorporates problem theory, which leads to the next stage of the D & D process.

Step 2: Create and Revise Program Materials

This step includes the creation of program materials for a new group intervention or a review of program materials of an existing intervention. Whether the materials are being developed new or are being considered for revision, this second step operationalizes the program theory, which normally culminates in the development of a preliminary manual (Fraser et al., 2009), which includes the essential components of the group intervention. Galinsky and colleagues (Galinsky, Terzian, & Fraser, 2006, p. 17) noted that there are two types of manuals, with some having “clearly structured content and activities” and others “more loosely structured and provide a series of topics for the practitioner.” With research projects involving strict controlled conditions, the manuals will have more structure to ensure fidelity. In such projects, measures of fidelity completed by participants and preferably independent observers are often used. However, even in controlled conditions, manuals should be flexible, allowing some latitude and creativity in application, as long as the *essential* elements of the session (which must be identified in the manual along with fidelity measures) are covered. The science and art of manual development in group work have been fully described elsewhere (Galinsky et al., 2006; Garvin et al., 2016), but general principles will be noted. Garvin and colleagues (2016, pp. 114–115) recommended that a group-based manual should include the following elements:

1. The purpose of the intervention approach; that is, the problem to be solved, the condition to be ameliorated, the change in people, groups, or environments that are sought
2. The population for whom the approach is intended

3. A comprehensive literature review that would include empirical studies, literature reviews, meta-analyses, and other systematic reviews of evidence that make clear how the program theory incorporates the problem theory
4. Involvement of practitioners and consumers in examining the materials and the practice procedures that evolve from these as the manual is developed
5. How to utilize group knowledge and group work practice principles in implementing the content of the manual in an actual group situation in the areas of group composition; how to help the group through the processes of early group development formation (e.g., development of rules and norms, clarification of purpose); the kinds of activities and exercises that should be employed and their sequence; a discussion of general group work practice principles that the practitioners should be mindful of as they implement the manual (e.g., respect for individuals, self-determination, mutual aid as members help one another, exploration of their processes by members, attention to group structures and indigenous leadership, and democratic decision making whenever possible and appropriate)
6. Discussion of implementation issues related to diversity (e.g. gender, ethnicity, age, sexual orientation)

An example of a manual that addresses key risk factors and attends to group process is *Making Choices: Social Problem-Solving Skills for Children* (Fraser, Nash, Galinsky, & Darwin, 2000). These types of group intervention manuals help maximize the likelihood that essential components of the intervention are both delivered and sensitive to group work practice principles (Galinsky et al., 2006).

CBPR and Manual Development

Manual development in CBPR involves all stakeholders in the design and development of the program materials. The first stage, evidence gathering and stakeholder involvement, was described earlier. The remaining three phases involve making program revisions based on the results from focus groups and preparing the materials for a pilot study (Bermúdez Parsai et al., 2011). For example, the content of the REAL groups was presented to parents, professionals, and other stakeholders through meetings and focus groups to ensure the material was appropriate (Bermúdez Parsai et al., 2011). This process helped to ensure that the program was culturally grounded and community based and that the groups would engage members in age- and culturally relevant ways (Marsiglia et al., 2010). This process resulted in a program (i.e., manual) representing the program theory that would have a positive impact on adolescent AOD use and other risky behaviors, fully vetted by all stakeholders.

Adaptation of Interventions

This step may also involve researchers examining the materials of an existing intervention to determine whether it should be adapted for a different age group, gender, or culture. Focus groups are often used in this process. For example, family group conferencing (FGC), which combines family and group work, brings together a family group with service providers to come up with a plan to resolve or mitigate significant problems in individual and social functioning (Macgowan & Pennell, 2001). As FGC was originally used outside the United States, a study was done to assess and improve the cultural responsiveness of FGC for three

racial/ethnic groups in North Carolina: African Americans, American Indians, and Latinos/Hispanics (Waites, Macgowan, Pennell, Carlton-LaNey, & Weil, 2004). The researchers used focus groups to gain community perspectives about the cultural appropriateness of FGC, which was being considered for widespread adoption across the state. These data provided invaluable information in determining the intervention's readiness for dissemination and how materials may need to be adapted. The researchers found that "consulting with community partners to develop a culturally competent model can help the partnership-building process between child welfare agencies and cultural (ethnic) communities" (Waites et al., 2004, p. 298). For additional discussion on adapting interventions to make them more culturally congruent and effective, see the models by Barrera and Castro (2006) and Marsiglia and Booth (2015).

In summary, this second step in the D & D of group interventions culminates in program materials that are ready to be further refined and tested in practice. The product is a preliminary group program manual.

Step 3: Refine and Confirm Program Components in Tests

Step 3 begins with pilot studies followed by increasingly controlled studies, which build "toward efficacy level analyses in which effect sizes are estimated for each major component or combination of components" (Fraser et al., 2009, p. 41). The goals of this step are to confirm the efficacy of the program components and to ensure that it is well received in practice. This section includes a number of areas that are salient in group-based intervention research, including pilot and controlled studies, adapting interventions, controlled studies of group processes and outcomes, and a brief discussion of analytical issues in group work research.

Pilot Study

The pilot often involves a single trial with a small convenience sample. The goals are to develop and refine the intervention in a practice context, using qualitative and/or quantitative designs. Several examples of pilot studies are cited.

Based on a well-documented program theory foundation (cited above), Najavits, Weiss, Shaw, and Muenz (1998) undertook a pilot study of a manualized 24-session outpatient CBT group designed to reduce AOD use and trauma symptoms. The study involved 17 women in three groups who completed measures at pretest, posttreatment, and 3-month follow-up. Formal measures were mostly quantitative and included assessing AOD use, trauma-related symptoms, and participant satisfaction with the groups. Overall, there were improvements on all domains, and members reported being satisfied with the groups. These findings laid the foundation for subsequent, more rigorous tests. Of note, however, was that the support of other group members was considered less helpful. Najavits and colleagues reported that

patients felt fear of being triggered by other group members with regard to their PTSD and substance abuse, felt competitive with them, and had interpersonal conflicts at times that they had difficulty resolving. Thus, a group for such severe patients in early recovery appears to work less by group affiliation and more by the presence of a strong theory, therapist, and containment model. Such results may suggest that the treatment could also be helpful if conducted as an individual treatment rather than as group therapy, though we have not evaluated this question. (p. 452)

These concerns were not raised in a subsequent pilot of Seeking Safety with incarcerated women (Zlotnick, Najavits, Rohsenow, & Johnson, 2003). Such data helped to further refine the intervention for subsequent trials.

Panzer and Dhuper (2014) piloted a group intervention to help young adolescents cope with interpersonal weight bias (e.g., teasing, bullying), which was introduced earlier in the chapter. In the piloting process, the researchers used informal quantitative measures (i.e., untested for reliability and validity) to assess the benefits of the program. Participants gained skill in coping strategies, and there was evidence of fewer episodes of teasing, up to 2 years after the program ended. These informal positive results provided a foundation for more rigorous testing that would include a stronger research design and reliable and valid methods.

In another example, Shechtman (2001) used both qualitative and quantitative methods to help understand intervention effects in piloting a 10-session group consisting of four aggressive elementary schoolchildren. Shechtman used case study methods in a comparison design that included four children in the intervention group compared to a single additional child who did not participate in the group. The study incorporated quantitative outcome measures of empathy and aggression (both teacher- and self-reported), as well as process measures of the stages of change and alliance with the group leader and with the group. Rather than hypothesis testing, the study used descriptive analyses with each of the five cases, noting that empathy generally increased and aggression decreased, but not with the child who served as the comparison. The process measures provided evidence that the intervention positively increased children's stages of change and that group and leader alliance scores were positively high. The researcher noted that, based on observations, the aggressive behavior was reduced through the experiential learning process. The author concluded:

As the children's sense of trust in the group and in the leader grew, they opened up to express themselves more freely and to accept feedback on their behavior. But it was the direct human interaction with suffering and pain that aroused empathy and self-awareness, and group members' encouragement that convinced the aggressive child that change is possible. (Shechtman, 2001, p. 234)

Sometimes pilot tests will identify procedures that need to be corrected. Marsiglia and colleagues (2010) undertook a preliminary pilot study of the REAL groups with fifth-grade students at risk for AOD use. The results were inconclusive, but the study provided methodological insights that would be addressed in a later efficacy study. For example, one of the problems in the pilot was that the referral process did not yield a high-risk group of participants, which brought into question both the appropriateness of targeting fifth graders and the quality of the screening and assessment measures. The subsequent study (Marsiglia, Ayers, Gance-Cleveland, Mettler, & Booth, 2012, described below) addressed these limitations. In addition, the researchers noted that the pilot study would have benefitted from feedback from participants about the group experience so that the findings could be better interpreted. Such pilot tests affirm their value in the process of D & D and of including qualitative measures to obtain member feedback.

Controlled Study

In the D & D process, the pilot study typically lays the foundation for a controlled study. A rigorous quantitative design, such as the randomized controlled trial (RCT), is best for

demonstrating intervention *efficacy*, defined as “the systematic and scientific evaluation of whether a treatment works” (American Psychological Association, 2002, p. 1053). Ideally, researchers conduct efficacy tests that maintain high control as program components are tested in a series of studies. Such studies may use both mediation testing to examine how proximal outcomes (mediators, such as communication skills developed in group) relate to distal outcomes (e.g., assertiveness) and moderation tests to determine what variables, such as race/ethnicity, gender, or level of acculturation, may affect proximal and distal outcomes. Studies in this step may begin with a strictly controlled study (e.g., RCT) or, in cases in which there may be an adaptation of an established intervention or in which conditions do not permit randomization, a rigorous quasi-experimental design. Several examples are presented.

Making Choices (MC) has been delivered both as a primary prevention intervention in classrooms and as a secondary prevention intervention in a small-group format coupled with a family intervention. In testing the secondary prevention intervention, Fraser and colleagues (Fraser, Day, Galinsky, Hodges, & Smokowski, 2004) used an RCT to test the effects of a combination of MC with Strong Families (SF) with 115 children who were identified by teachers as having concerns with aggression or peer rejection. The MC program was delivered in a small-group format and included 30 lessons related to developing problem-solving skills and reducing peer rejection. The lessons were intended to help participants build friendships, manage social situations in nonaggressive ways, and work productively in groups. SF was an in-home intervention to build parenting skills such as setting limits, problem solving, and rewarding prosocial behavior (Fraser et al., 2004).

Fraser and associates (2004) randomly assigned 62 children and their parents to MC and SF and 53 children and parents to a wait-list condition. To minimize concerns about aggregating aggressive children who might engage in member-reinforced disruptive behavior, the groups included teacher-nominated prosocial peers who were drawn from a pool of students on the same grade level, had consistent attendance, and demonstrated prosocial skills. This strategy also allowed the children to develop a network of prosocial peers. The results of the efficacy trial showed that children in the MC + SF program showed significant gains on all but one outcome measure. Specifically, the program strengthened participants' prosocial behavior, emotional regulation, social contact, cognitive concentration, and relational aggression, but not authority acceptance. Participants in the control condition did not show such gains. One of the limitations of this study was that it did not examine the relative contributions of MC and SF to outcomes. Additionally, the study did not control for the clustering effects of groups, which may have affected the accuracy of findings. This study also demonstrated that not all intervention development programs follow a clear path. In this case, the group intervention was coupled with a family intervention, and the respective contribution of MC in the group format to outcomes was not examined. To accomplish that goal, a dismantling design would be needed (for more discussion on dismantling strategies, see Kazdin, 2003; Resick et al., 2008).

Fraser and colleagues also tested the effects of MC as a primary prevention model delivered in classrooms. Fraser's research group completed a series of studies that helped illuminate which students the program benefitted. For example, one study (Terzian, Li, Fraser, Day, & Rose, 2015) used a controlled quasi-experiment of the MC program, which improved on a previous study (Fraser et al., 2005) that had lacked a full examination of pretest to posttest changes. To permit such a comparison, Terzian and colleagues included three cohorts of third-grade students ($N = 479$). The first cohort received MC, a 29-lesson

program that included group exercises. The second cohort received MC Plus, which added family and teacher involvement and consisted of didactic training, application activity manual, and 4 weeks of a “good behavior” game. The third (lagged) cohort received a standard health education curriculum, allowing for the comparison of pretest to posttest changes. Another strength of this study was the incorporation of analytical methods to control for classroom effects, which is recommended when programs are administered at the group (and classroom) level (Krull & MacKinnon, 1999). Specifically, the analyses included computing intraclass correlations (ICCs), which indicated the need for multilevel modeling (hierarchical linear models [HLM]; Raudenbush & Bryk, 2002). In addition, the study incorporated controls for possible moderators (e.g., gender). The findings revealed significant reductions in boys’ aggression, with large effect sizes, and significant increases in positive social goals (no significant changes were found with girls).

Along with RCTs, studies of group interventions in this step may utilize a controlled quasi-experimental design that builds on a noncontrolled pilot study. For example, Marsiglia and colleagues (2012) undertook a controlled study of the REAL groups secondary prevention program, which was designed for students of Mexican heritage who were either at high risk for, or already experimenting with, AOD use. Building on limitations uncovered in the pilot study noted above (Marsiglia et al., 2010), the controlled study (Marsiglia et al., 2012) adapted the intervention for older seventh-grade adolescents who were in two conditions: one that included 102 students who participated in the REAL groups and a matched comparison group of 102 participants who did not participate in the secondary prevention. To account for the biases in the selection process into the REAL groups, propensity score matching (PSM) was used (for more on this approach, see Guo & Fraser, 2015). A propensity score was first calculated based on key AOD risk covariates (i.e., demographics, AOD use exposure, behavioral risk factors, and parental closeness). Participants were then matched on their likelihood (propensity score) of participating in the REAL groups, which helped to control for the covariates, creating a balance between groups (Marsiglia et al., 2012). PSM does not replace true random assignment, but it allows for control when randomization is not possible or desired. The study reported that participants of the REAL groups had significantly lower odds of using alcohol compared with the matched controls. The study provided support that REAL groups was an effective secondary prevention program for adolescents at higher risk for alcohol use. This study is an example of the value of including an additional group intervention component targeting a specific subgroup at higher risk. This study would need to be replicated in an RCT to confirm the preliminary findings before moving to the next step of the D & D process.

Adaptations of Interventions

Interventions are initially adapted in the first two steps of the D & D process, when materials are reviewed and modified based on additional findings from the literature and/or through feedback from focus groups. However, the piloting and early efficacy tests of the revised intervention are done during step 3. Three types of adaptations are described: (1) group interventions tested with a new population and intervention components; (2) group interventions tested with a new problem; or (3) interventions designed for individuals are adapted for group work.

Sometimes group interventions are tested with new populations or intervention components to see whether they perform as well as in previous studies with different participants

or components. For example, one of the tests of the Seeking Safety group intervention involved applying Seeking Safety with 117 male veterans with co-occurring AOD use and PTSD in an outpatient treatment clinic (Boden et al., 2012). Additionally, the study did not test the efficacy of Seeking Safety alone but only how it did in combination with routine services in a practice setting. The study also included an examination of how mediators (proximal outcomes), such as treatment attendance and changes in coping, were associated with outcomes.

The researchers randomly assigned 59 participants to Seeking Safety (plus routine services) and 58 participants to treatment as usual (TAU), and outcomes were measured at baseline, end of treatment, and a 3-month posttest. The study also included an intent-to-treat analysis consisting of all participants, regardless of their level of attendance. A limitation in the methods of this study was the lack of control for the clustering effects of groups. This study reported that drug use outcomes were significantly lower among those in TAU, but alcohol and PTSD severity declined significantly in both conditions. Additionally, participants in Seeking Safety had significantly better attendance, coping, and satisfaction with service, but none of these mediators were associated with AOD use. This study was one in a series of carefully controlled group-based studies of Seeking Safety involving different samples and dosages, which helped refine and confirm various components of the program theory (Najavits & Hien, 2013).

A second type of adaptation occurs when a researcher adapts an established group intervention for a different problem in a naturalistic setting. For example, Erickson (2003) examined the potential effectiveness of a group CBT for mixed anxiety disorders in a clinic setting (previously it was effective with a single anxiety disorder in controlled settings). The 12-week group included elements that were common to many anxiety disorders, “as well as CBT techniques unique to panic, agoraphobia, social phobia, GAD and PTSD” (Erickson, 2003, p. 185). The researchers used a quasi-experimental, single-group, pretest–posttest design, which included a 6-month follow-up. The study reported that the intervention produced significant and substantial reductions in anxiety at posttest and at follow-up. The authors concluded that they would progress to a controlled trial of the heterogeneous group format.

The previous examples consisted of intervention studies that evolved from previous research. Sometimes group researchers may want to adapt an individual intervention for the group modality. Research on the relative efficacy of individual versus group modalities is another type of group intervention study that has been done many times (for a review, see Burlingame, Strauss, & Joyce, 2013). However, rather than simply aggregating individuals into the group format for the sake of economy, researchers should also indicate how an intervention may “translate” into the group format. Ignoring the implications of moving interventions from the individual to the group format can decrease their effectiveness (Burlingame, Mackenzie, & Strauss, 2004).

Wilfley, Frank, Welch, Spurrell, and Rounsaville (1998) provided an outline for modifying existing individual interventions to the group format, which they used in developing a group-based form of interpersonal psychotherapy from the individual format. They described five key questions to answer in adapting treatments across the individual to the group modality, which would preserve the “core” elements. First, what are the effective change processes of the individual treatment, and how will they be preserved in the group format (active ingredients)? Second, how will a focus on each individual’s work be maintained in the group format? Third, how are the therapist and client roles characterized in

the individual treatment format, and how will those be maintained in the group modality? Fourth, what are the techniques of the individual treatment, and how will they be delivered in the group format? Fifth, what group processes should be considered that would maximize effective implementation of the individual treatment (e.g., use of other members, therapeutic tasks through stages of group development)?

For example, there are unique features of group work that can potentially enhance the effects of member commitment to change in group-based motivational interviewing (MI), which has been typically done with individuals. One study found that leader empathy was linked to two change-talk mediators (group commitment and peer response), which affected drug use outcomes. Specifically, groups with more empathetic leaders expressed less negative and/or more positive group commitment and peer response, which resulted in lower marijuana use outcomes (Engle, Macgowan, Wagner, & Amrhein, 2010). This and other studies using motivational enhancement interventions in groups (Santa Ana, Wulfert, & Nietert, 2007; Sobell, Sobell, & Agrawal, 2009) highlighted the importance of considering group factors in the translation of interventions from individual to group work.

Controlled Studies of Group Process and Outcomes

Burlingame and colleagues (2013) identified factors that contribute to group outcomes, which they referred to as the *anatomy* and *physiology* of groups. The anatomy of groups is the structures of the group that set the limits on physiological function, which may be either *emergent*, deriving from the group itself, such as norms, subgroups, and group development, or *imposed structures* by the group worker, such as member selection, pregroup preparation, and composition. The physiology refers to group processes consisting of *foundational social processes*, such as performance, role functioning, conformity, power, and conflict and *emergent processes* related to member–leader interactions, such as therapeutic factors, interpersonal feedback, and leader interventions. Extensive research has identified how these areas contribute to group outcomes. However, many group-based studies ignore these aspects of groups, resulting in inconclusive and incomplete findings (Burlingame et al., 2013), thus further demonstrating the importance of examining processes and outcomes in group-based intervention research.

One example examined the effects of individual and group factors on changes in child-rearing practices among 496 parents enrolled in a parenting program in Spain (Byrne, Salmela-Aro, Read, & Rodrigo, 2013). Byrne and colleagues (2013) expected that individual and group variables would contribute to variations in effectiveness of the program and would inform the researchers “about the critical ingredients that contribute to program success under real-world conditions” (p. 47). The group factors examined were group size (small and medium vs. large) and group composition (e.g., risk status of families) across 94 groups receiving the parenting program. The outcomes examined included positive (inductiveness) and negative (negligence, permissiveness, coerciveness) parenting practices.

The researchers found that parenting outcomes were affected by group composition, but not by group size. The authors speculated that the large groups (13–29 participants) likely did well due to the well-trained professional facilitators who were able to effectively manage the large groups. Group composition, however, produced significant effects. Specifically, “low-risk groups and mixed (at-risk and not at-risk) groups did better than medium/high-risk groups in changing inductive and coercive practices whereas all groups did well in changing permissive-neglecting practices” (Byrne et al., 2013, p. 46). Because the

researchers examined within-group factors (i.e., structures) and controlled for group effects over time using latent growth curve modeling (a form of HLM), they were able to produce more reliable group-based information, which can be used to improve the effectiveness of group-based parenting interventions. In the development of effective group-based interventions, these types of studies are essential to illuminate group factors that relate to outcomes. As Burlingame and colleagues (2013) recently noted, “future progress must include measures of well-known group properties to at least rule them in or out as potential mechanisms of change” (p. 668).

Analytical Issues in Controlled Group-Based Research

Grouping individuals in a context of social interaction brings analytical complexities to intervention research. Individual group members are nested within groups, which affects the members’ behaviors; the group changes through time in a developmental process; and data collected from one group are likely to be both similar and dissimilar to data collected from different groups (Miles & Paquin, 2014). Statistical methods should take into account such complexities, or inaccurate results may occur (Baldwin, Murray, & Shadish, 2005; Baldwin, Stice, & Rohde, 2008). Two of the controlled studies reviewed above used approaches to deal with the dependence of group data (Byrne et al., 2013; Terzian et al., 2015). Such methods may include ICC analyses, multilevel modeling, and the actor–partner interdependence model. It is beyond the scope of this chapter to discuss these approaches, but readers are directed to the literature for more information on modeling that can control for data dependencies (Garvin et al., 2016; Lo Coco, Gullo, Prestano, & Burlingame, 2015; Miles & Paquin, 2014; Tasca, 2016) and changes in group membership that often occur in open-ended groups (Morgan-Lopez & Fals-Stewart, 2007). These tools allow group intervention researchers to effectively and appropriately study the many dimensions of group experience (Burlingame et al., 2013).

Step 4: Test Effectiveness in a Variety of Practice Settings

Once the intervention is refined and the mechanisms are understood, it is tested in a variety of settings in effectiveness studies. Intervention *effectiveness* is defined as “how well an efficacious treatment can be transported from the research clinic to community and private practice settings” (Chambless et al., 1998, p. 3). Whereas efficacy research maximizes internal validity, effectiveness research promotes external validity, or how the research may apply in naturalistic settings in clinics and in the community. Ideally, research should be both efficacious and effective in different clinical contexts, as this improves the applicability of an intervention. Research studies at this step help bridge the research–practice gap by examining the process of implementation across settings and clients. These are community-based, rather than strict university-based, programs, and this allows the naturalistic use of the intervention in a real-world setting. Thus practitioners rather than researchers provide the intervention, but the research team might be involved in training, data collection, and analyses (Fraser & Galinsky, 2010).

Most of the research on Seeking Safety has been in the form of effectiveness rather than efficacy studies, with results that demonstrate the program’s “ability to produce positive outcomes in real-world conditions” (Najavits & Hien, 2013, p. 442). Some effectiveness studies do not include outcome data but rather provide detailed implementation information, which includes mixed designs. For example, one mixed-methods study examined the

implementation of Seeking Safety groups in four sites across the United States involving 157 women with co-occurring disorders and histories of physical and sexual abuse (Brown et al., 2007). The conditions of the interventions were not controlled across the sites. The three main research questions of the study were: (1) What decisions did the different sites make in order to optimize the compatibility of Seeking Safety with the site's needs and experiences? (2) How satisfied were the clinicians/facilitators and consumers/clients with Seeking Safety, and were there differences between sites and between clinicians and consumers? and (3) What may be important factors that contribute to the adoption of new practices? (Brown et al., 2007, p. 232).

Brown and colleagues utilized a quasi-experimental design that included Seeking Safety (experimental condition) and a comparison condition of TAU (e.g., nonintegrated and non-trauma-specific services). In addition to quantitative measures of satisfaction with services, focus groups were used to collect comments about the intervention process. Each of the four sites used the manual flexibly, as intended, which allowed comparison of results across the sites and for local cultural adaptations. For example, at one site, examples of racism were added as traumatic events. To help understand the application of the model in "real world" settings, the study incorporated quantitative measures about program components that were completed by both clients and therapists, and a focus group was conducted with participants. Detailed analyses were done on many aspects of the program and compared across the selected sites, such as the treatment manual, lists of treatment resources, and ratings of helpfulness of Seeking Safety.

The researchers reported that although all sites had high satisfaction ratings, one site had significantly lower ratings than the others. These data on program components helped to provide program refinements. In addition, the qualitative data identified three most important parts of the treatment: "(1) the group experience—feeling safe, bonding with other women who had similar experiences; (2) learning about coping skills; and (3) receiving information about PTSD and substance abuse" (Brown et al., 2007, p. 238). Thus the detailed examination of the program components in different settings across different group workers helped to identify areas for dissemination. By the end of the study, all four sites had adopted the program and disseminated it to others beyond the test site.

Effectiveness studies may also be conducted with well-established interventions to understand the mechanisms of the group intervention in community settings. For example, Levac, McCay, Merka, and Reddon-D'Arcy (2008) used a qualitative case study approach to acquire parents' views of the effectiveness of the established group-based Incredible Years Parent Training (IYPT) program. The study helped identify the underlying mechanisms of the intervention, revealing how and why changes occurred. Important findings included the following:

When parents feel accepted, supported, and not blamed by healthcare professionals, they seem to be able to engage in self-reflection specifically related to their parenting styles. In turn, their ability to reflect in the group and make sense of their own thoughts, feelings, and behaviors seems to have a positive influence on the process of change in themselves, their children, and in their relationships with their children and other family members. (Levac et al., 2008, p. 78)

Although IYPT had been tested using quantitative methods alone, the qualitative data helped refine and validate components. Such data would not have been available without qualitative methods.

By the end of the fourth step of the D & D process, the program theory has been tested in both efficacy and effectiveness trials and is ready for dissemination—ideally. Sometimes, group researchers may cycle again through the steps in a process of refinement.

Step 5: Disseminate Findings and Materials

The final step involves disseminating program findings and materials to researchers and practitioners, typically through conference presentations and academic journals. Garvin and colleagues have an extensive discussion about reporting and disseminating group work research in their book (Garvin et al., 2016). In addition, program materials may be disseminated through the Internet, making the material readily available to practitioners. For example, information about using Seeking Safety is available at a website (www.treatment-innovations.org).

Dissemination provides the opportunity for practitioners to begin accessing and using interventions, representing the KU facet of intervention research described at the outset of the chapter. Under the umbrella of KU, evidence-based group work (EBGW) is a model to guide group workers in the process of integrating the best available intervention evidence into practice. Macgowan (2008) has described EBGW as a four-stage process in which group workers (1) formulate an answerable question derived from practice; (2) search for evidence; (3) undertake a critical review of the evidence to identify the “best available evidence”; and (4) apply the evidence with judgment, skill, and concern for relevance and appropriateness for the group, utilizing evaluation to determine whether desired outcomes are achieved. Practitioners can use the model to help apply group intervention research to practice.

Adaptations of Interventions by Practitioners

As a result of dissemination, group workers may come across an intervention and want to adapt it to their local context or for their clients. As a general rule, group workers should maintain the integrity of the original intervention and not adapt it (Elliott & Mihalic, 2004; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). However, some researchers permit the flexible use and adaptation of their intervention. For example, the developers of Seeking Safety noted that the full 25 topics related to the intervention do not need to be covered and suggest which topics should be covered (www.treatment-innovations.org/faq-research.html). If it is unclear from the materials whether an intervention can be adapted, group workers should contact the developer of the intervention (emails are listed on the first pages of publications) to (1) inquire whether an adaptation has been done, (2) ask the developer to clarify the essential elements that need to be maintained, and (3) determine whether an adaptation can be done in consultation with the developer (Barrera & Castro, 2006; Marsiglia & Booth, 2015). Exchanges between group work researchers and practitioners can ensure that efficacious interventions have broader applicability and relevance in the real world of practice (Horneland, Bornes, Hoby, Knutsen, & Lorentzen, 2012).

Sometimes a discussion between a practitioner and the research team becomes a formal collaboration to evaluate an adapted intervention, which would move the intervention back into Step 4 of the D & D process. As an example of this possibility, the developers of Seeking Safety provided a website (www.treatment-innovations.org/seeking-safety.html), where they noted that they “are happy to collaborate or consult on studies. We have extensive experience conducting outcome research. We can provide consultation on research design and measures, train you to conduct fidelity monitoring, conduct the evaluation portion of a project, and if desired, can analyze your data and write it up for publication.”

SUMMARY AND CONCLUSIONS

This chapter presented an overview of a 5-step model of designing and developing group interventions. Relative to other disciplines or modalities, there has been little intervention research in social work with groups. Researchers are encouraged to use the D & D process to develop or adapt existing interventions for group work. Examples of a range of group-based interventions that focused on outcomes, process, and processes and outcomes were presented. In addition, examples were given of group interventions that were adapted to accommodate problems or populations that were different from those originally intended and of the process of adapting individual interventions to the group modality. In particular, there was a call for wider use of appropriate analytical methods that take into account the multilayered and interactive nature of group work. In adapting interventions for practice, practitioners can collaborate with academic researchers to together help build the science base of interventions in social work with groups.

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PART VII

THE USES OF TECHNOLOGY TO CREATE GROUPS

INTRODUCTION

There is only one chapter (Chapter 33) in this section, devoted to an emerging area of group work practice. Increasingly, workers utilize the telephone and/or the computer to help members obtain the benefits of groups. This often occurs when it is difficult or impossible for them to meet face-to-face, for such reasons as the geographical dispersion of the members or their physical limitations.

A growing body of experience and research is available that can help the practitioner determine the effects of such groups on members, the ways these groups may be created, the interventions that are utilized to facilitate such groups, and how they may be evaluated. There are differences in these situations that relate to the media utilized, such as whether members interact at the same time or at other times that may be more convenient, or whether the device is a phone or a computer, and how members are “known” to each other. Chapter 33 provides information on these and many other relevant issues.

CHAPTER 33

Technology-Mediated Groups

DALE FITCH

The previous edition of this *Handbook* was published in 2004. (Andrea Meier wrote the chapter on technology-mediated groups.) A search in PsycInfo was performed to provide a frame of reference concerning publications about online or technology-mediated (TM) group therapies since that time. From 1976 through 2003, 17 articles were published using the search phrases *group therapy* and *online*. In the period from 2004 through April 2015, 173 articles were published using those same phrases. Clearly much has changed since 2004. Assuming the number and types of therapies have not drastically changed, then the ever-quickenings changes in technology appear to be in play. Therefore, this chapter restricts itself from some of the more general forms of TM group practice, such as telephone and email, and focuses on the modalities reflected in the empirical research captured by these 173 articles.

MENTAL HEALTH NEEDS

As outlined by Kazdin and Blase (2011), in no way can we consider current methods of delivering psychotherapy or counseling as meeting the needs of the general population. The labor demands of delivering therapy either individually and/or in groups will never meet these needs. In that regard, and as voiced by others, technology must be pursued as a means to increase access to mental health services where appropriate and through means that measurably meet the mental health needs of those served. In that regard, the burgeoning amount of empirical studies indicating the efficacy of online group therapy needs to be acknowledged as we move forward to train practitioners for new practice demands. For those who may still underappreciate the reasons that this unmet demand is taking place, the literature provides a very clear picture describing issues related to distance, time, and anonymity. Most importantly, not one single study identified cost of services as a reason that contributed to lack of access.

Distance

The literature is becoming clearer as to the reasons why clients with mental health needs are not utilizing face-to-face treatment options (Andersson et al., 2013; Gilkey, Carey, & Wade, 2009; Wade, Wolfe, & Pestian, 2004). At the top of the list are access issues related to time and distance. By definition, people living in rural and remote areas are de facto excluded from any form of group therapy simply due to the fact that a critical number of people are necessary to form a group within a given geographic region. On the other hand, many of these same individuals may have smartphones or other communication devices that could let them access online services without restriction to a geographic region. Even in studies in which access issues are not explored as a control variable, the client demographics speak for themselves. For example, Andersson and colleagues (2005) reported a disproportionate number of participants in their study from nonurban areas of Sweden, even though that was not a targeted aspect of their study. Also, one cannot help noticing that many of the studies cited in this chapter in sparsely populated locales, for example, Australia (see, e.g., Ellis, Campbell, Sethi, & O'Dea, 2011; Griffiths et al., 2012; Heinicke, Paxton, McLean, & Wertheim, 2007; Hucker & McCabe, 2014).

Time

Sometimes, but not always associated with distance, the issue of time contributed to lack of access to group therapy. Time becomes an instrumental barrier even in urban settings once one factors in the time necessary to travel to and from appointments, squeezing appointments around work schedules, and accounting for familial responsibilities, especially in single-parent households and/or those with multiple-dependent care responsibilities. Conversely, practitioners must take all of these factors into account when trying to form groups and finding compatible schedules for 5–10 people. Treatment groups are then sometimes formed around issues of scheduling as opposed to client–treatment intervention match.

Anonymity

As discovered by Heinicke and colleagues (2007), when treating adolescent girls for eating disorders, and by Hucker and McCabe (2014) when treating for sexual dysfunction, neither one of these populations would have attended a traditional therapy setting because the need to disclose their identities would have precluded seeking help. Conversely, the anonymity provided by the two text-based interventions allowed them to receive help, “meet” others with similar issues, and share struggles and successes and can lead to healing and recovery. Expressions most often associated with in-person groups, such as, “it feels good to know I am not alone”; “it is helpful to know I am not walking alone”; and “I was nervous thinking about sharing my issues with other people, but I already feel a lot better about myself” are very common in online groups. While not a central focus of their study, Berger, Hohl, and Caspar (2009) also provided anonymity for their clients with social phobia, and they had similar responses. To contemplate that all of these individuals had cut themselves off from traditional treatment due to fears of self-disclosure would be untenable if they had not been afforded the anonymity and help provided by a TM group.

In sum, an unintended consequence when all of these barriers are taken into consideration is that the people we most often see in group settings and research studies may be very much unlike the entire population of people who could benefit from group therapy.

Notwithstanding the large number of people who are inconvenienced by distance, time, and anonymity barriers, an unknown number of people are impeded by other factors, such as being physically disabled, victims of severe domestic violence who cannot easily leave their homes, or the elderly who may wish to limit their driving. Furthermore, knowing that lower-socioeconomic status (SES) members disproportionately receive fewer in-person group services due to a combination of all of the previously mentioned barriers, it is heartening to see that, controlling for SES, participants in some studies had equal treatment outcomes once provided the opportunity to access TM group services (Carey, Wade, & Wolfe, 2008). Only when TM practice is more commonplace will we be able to carry out studies that can assess these possible population differences.

PURPOSE OF THE CHAPTER

With this background and these needs in mind, this chapter describes the TM group modalities and issues related to conducting a group online, provides an overview of the research done on TM groups, discusses concerns related to privacy and confidentiality for TM practice, and outlines best practices that are emerging in this ever-evolving field. For the sake of brevity, traditional in-person group therapy is referred to as F2F (face-to-face) groups, and online groups will be referred to as TM groups. The chapter closes by discussing future research challenges.

TM GROUP MODALITIES

One of the most startling observations when reviewing the literature on TM practice is that almost no two authors describe it in the same way. More concerning are cases in which claims are made about the efficacy of a certain approach when practitioners are conducting TM group practice in very different manners. For example, one of the most frequent assumptions pertains to synchronous versus asynchronous groups. The former is most easily understood as taking place through a videoconference call, for example, Skype, or through chat instant message. In this setting, the practitioners and all group members are present at the same time. Asynchronous groups can be more easily understood as Web-based discussion groups in which members, including the practitioners, post messages at different times, but usually within a given week.

More subtle in distinction would be modalities that approach TM practice in a hybrid fashion. That is, although there may be a central focus of the group, interventions can be augmented by emails to individuals, phone calls, self-directed readings (bibliotherapy), open or closed online discussion forums, and/or any combination thereof. Nonetheless, the central focus for asynchronous TM practice is the use of an online “discussion forum” that is characterized by text responses to either practitioners’ prompts and/or fellow group members’ posts. The practitioners’ interactions with these posts vary by practice strategy. Discussion forums can also augment synchronous TM practice in which each participant uses a video camera and microphone to engage with each other and the practitioner in real time, for example, through the use of Skype or other videoconferencing tools. This approach, too, varies widely by practitioners, with variations in all of these practices discussed in more detail in the following sections.

Current TM research also reflects established group practice methods in which interventions typically extend over 8–15 weeks. However, several researchers noted the question as to whether these timelines had to be married so closely to F2F practice (Griffiths et al., 2012; Hedman et al., 2014; Lemma & Fonagy, 2013). As discussed in the next section, a formal “engagement” period may need to begin prior to group work in which prospective clients are assessed for technology proficiencies, educated on how online group practice takes place, and given specific instructions on how to use the online group meeting software. With the advent of a self-help component to a group intervention, coupled with the use of open or closed online discussion forums, the concept of a TM group extending over an indeterminate time frame should also be considered.

ENGAGEMENT

Although the literature on engagement in group work is well established (Macgowan, 1997), what “engagement” means for TM practice is still emerging. Some studies have examined how well typical F2F engagement strategies can be used in TM practice—specifically, assessing eye movements and facial expressions as a key step in assessing emotional responses. Liess and colleagues (2008) examined session videotapes and transcripts to determine how the identification of emotional responses from text compared with watching the videotapes. The results indicated that people tend to overestimate positive responses and underestimate negative responses when examining only text. The implication is that a practitioner doing TM practice that was text-based only would not be able to function properly if emotional regulation were a key component in the intervention. On the other hand, one might argue that formulating our thoughts and expressing them via text may precede emotional expression, especially if the behavior is new or the person is primarily introverted. Certainly more research in this area is warranted.

Regardless, even in this early developmental phase, some themes as to what engagement means are becoming better understood. For example, both practitioners and clients report being surprised as to how well they believed they actually obtained an understanding of the other as a person. That is, even though some of the modalities had only a text-based interface, both practitioners and group members thought the use of words and phrasing allowed for a kind of intimacy not always experienced in F2F work (Lemma & Fonagy, 2013). This was especially true for those individuals who suffered from anxiety disorders or who thought they needed extended time to process an interchange before responding. Having that extended time to process new thoughts and feelings is not possible in an F2F group, whereas it is a natural feature in a text-based, asynchronous group.

Somewhat surprising were the number of studies that reported on the emotional and affective dimensions of TM group members. Often cited as a reason *not* to use online technology is the fact that it is not possible to detect body language and facial expressions that can illuminate group processes.

Damianakis, Climans, and Marziali (2008) found that even text-based TM groups are beginning to demonstrate that they, too, are very capable of providing the means for participants to share a full range of emotional responses. For example, someone who is happy or sad can simply type (smile) or (sad) at the end of a sentence, indicating the emotional conveyance. With smartphones and other texting interfaces, more and more people are starting to use emoticons (☺) in their daily interactions, especially if the message can be interpreted in various ways. Some interventions are beginning to intentionally include education on using

emoticons in their online training materials so that participants can have multiple means of expressing emotional content or states of mind.

SUPPORT

Perhaps due to the introduction of technology into the therapeutic relationship, practitioners in the cited studies appear to be creating new therapeutic relationship boundaries. For example, they realize it is not easy to differentiate therapy-related questions from technology-related questions when attempting to support clients in successfully managing the online technologies (see, e.g., Damianakis et al., 2008). For instance, some group work practitioners maintain strict boundaries in that practitioner–group member communication must only occur during group so that the “group process” is honored. Other approaches include individual work that occurs simultaneously with group work. However, in both situations all group members fall within the same treatment practices in order to maintain treatment fidelity.

Such is not the case with emerging TM groups. Several studies outlined intervention protocols that were amended once they began. Most of the changes pertained to making the practitioners or practitioner aides available to participants via telephone or email on an as-needed basis (see, e.g., Hucker & McCabe, 2014). Ostensibly to troubleshoot technical issues, it quickly became apparent that some group members, while adapting to the online environment, needed more frequent feedback than what was experienced through the already established group forum and/or weekly practitioner contact. The need to understand better these participant types is an identified issue for future research, as discussed in the last section. Conversely, some practitioners realize that the availability of email makes it much easier to reach out to clients individually and immediately as needs arise. For some, this was felt to be a way to individualize treatment to better meet client needs.

DIAGNOSES

Research trials cover a range of diagnoses, including depression (Andersson et al., 2013; Boggs et al., 2014), sexual dysfunction (Hucker & McCabe, 2014), anxiety disorder (Hedman et al., 2012, 2014), traumatic brain injury (Carey et al., 2008; Gilkey, Carey, & Wade, 2009; Wade, Carey, & Wolfe, 2006; Wade et al., 2004), anger management (Greene et al., 2010), and social phobia (Berger et al., 2009). It is to be noted that in every study cited and reviewed for this chapter, having a diagnosis of only a mild or moderate form was thought to be suitable for a TM approach. In every case in which the screening or assessment criteria indicated a severe diagnosis, the client was referred for an in-person appointment and was excluded from TM services.

PRACTICE STRATEGIES

In a book chapter of this size, it is impractical to cover the 173 articles in depth sufficient enough to do service to the merits of the studies they describe. As such, exemplar strategies are highlighted in view of their practice features that shed light on the use of technology.

Psychoanalysis

Based in psychodynamic theory, this approach is used less frequently in TM groups for which empirical evidence is available. Indeed, it is an approach one would think would be averse to the use of technology in light of the very heavy focus on the analytical relationship developed via intense interpersonal interactions that are necessary to produce transference phenomena. Nevertheless, this approach, too, has acknowledged the need to widen its traditional practice styles to increase access to clients who many not benefit from CBT or other treatment strategies (Lemma & Fonagy, 2013). Similar to many TM approaches, initial phases of treatment involve the provision of reading materials to participants via email that explain the importance of interpersonal relationships. Later phases of treatment shift to dialogue in online discussion forums.

Lemma and Fonagy (2013) explicitly examined the role of the practitioner in using this approach in three different groups: in one, materials were provided to the members and the practitioner facilitated all group interactions and was available during the week at specific times to respond to members' posts; in another, the members had access to all the materials and a closed online forum without a practitioner; and in a third, comparison, group, members had access only to the open forums provided by the website.

Perhaps surprisingly, the findings indicated that the materials-only condition was the most helpful, but that benefit was also perceived to be derived from the practitioner. Most noteworthy, though, was that the group that could have met online to discuss issues without the practitioner present largely chose not to do so. They had the highest attrition rate compared with the control group, which had no practitioner and no online forums. In sum, and as evidenced by emerging research, TM delivered through bibliotherapy alone can have a significant impact. However, the respondents also noted their preference in being able to opt in and out of interactions with each other and the practitioner based on their own feelings of safety and comfort. Indeed, this is not possible in F2F groups without causing some level of disruption.

Cognitive-Behavioral Treatment

Mirroring the dominance of CBT approaches in the research literature is its primacy in the TM group literature. In many ways CBT is ideally suited for TM practice in that most CBT interventions begin with didactic reading material that is read by group members at their own pace. This is coupled with the ability to pose questions to discussion forums when new concepts or terms are encountered. After the bibliotherapy phase, which can range from 1–3 weeks or longer, new “ways of thinking” are explored via online group sessions. On the other hand, some interventions are entirely client-paced, with fairly open-ended time frames for completion. There are widely varying uses of the group component to these interventions because of these dissimilarities. For example, some interventions had no active practitioner involvement and functioned much more like a support group (Andersson et al., 2013).

Other CBT interventions are more reliant on a practitioner's involvement in the group process. Greene and colleagues (2010), explicitly examined those process issues by comparing treatment outcomes for an anger management group and a synchronous videoconferencing group. In sum, there were no significant differences. Not only were there no differences in treatment outcomes, but there were also no differences in attrition, treatment adherence, and satisfaction with the therapeutic process between the two groups.

Exploiting other capabilities of the Web to deliver audio and visual CBT materials has been the focus of other studies (Berger et al., 2009). That is, does making fuller use of audio and video media, coupled with interactive behaviors, for delivering CBT materials enhance treatment outcomes compared to simple bibliotherapy, such as PDF-formatted didactic material? As found by Berger and colleagues (2009), the answer is largely no. While both groups reported satisfaction with the ways they received the treatment materials, one approach was not felt to be better than the other in achieving treatment outcomes.

Conversely, audio and video features were instrumental in helping clients achieve treatment success when the intervention involved a CBT intervention for depression that was coupled with meditation techniques (Boggs et al., 2014). Although the didactic text was not benefitted by the audio and video components of the intervention, for example, a videotaped lecture, the participants did identify as helpful the audio files that read aloud the text of the meditative materials. Unfortunately, the group component of this intervention consisted of watching videotapes of group sessions. Not surprisingly, the participants said it would have been more helpful if they could have interacted with each other online.

Self-Help Groups

Because this chapter foregrounds the role of the practitioners, the self-help research literature was not exhaustively examined, as that would have increased the number of articles beyond the large number already reviewed. However, many of the therapy-focused TM practice approaches used self-help groups as an adjunct to practitioner-led interventions. For example, Griffiths and colleagues (2012) found that practitioner-provided content *with no further practitioner contact at all* and only support group assistance was just as effective as practitioner-involved treatment.

The Andersson and colleagues (2013) study was particularly insightful in this regard, as a self-help group was used as a control group for a practitioner-led group. Unlike other studies that found benefit with self-help groups alone, his study did not reach a similar conclusion, with the premise being that the group members knew they were on a waiting list and hence they did not put concerted efforts into the bibliotherapy materials provided to the intervention group. Similarly, Griffiths and colleagues (2013) found that compared with self-help alone, having access to practitioner-provided bibliotherapy was more effective when the two were combined. Interestingly, the two combined were more effective compared with practitioner-provided bibliotherapy alone, lending credence to the efficaciousness of the group component.

PRIVACY AND CONFIDENTIALITY

Despite the growing empirical literature that demonstrates the efficacy of TM group practice, the number one ethical issue concerning TM practice is whether privacy and confidentiality can be assured when using technology. As covered by Reamer (2013, 2014), online technology has introduced an array of ethical issues and challenges that will require the augmentation of existing practice frameworks and training. Beyond social work, other mental health professional groups have promulgated ethical and practice guidelines to assist clinicians and inform clients (Haberstroh, Barney, Foster, & Duffey, 2014). In addition to disciplinary groups, transdisciplinary organizations have also formed, such as the International

Society for Mental Health Online (ISMHO), in order to meet the demand for guidance and understanding required in this ever-evolving practice arena.

However, counter to nonprofit organizations such as ISMHO are vendors and proprietary organizations that provide their specialized services and technology. Enter “online therapy” into any search engine, and almost all of the initial entries will be links to commercial providers or vendors. Unless one is well versed in the technological nuances of what is being promoted, one may be left with the impression that only certain technologies can be used in online environments.

The promotional material will oftentimes conflate technology with practice and offer a “product” to meet the needs of today’s busy, online professional. Yet, upon closer examination, only two elements are in play: (1) Ethical practice that assures privacy and confidentiality and which is oftentimes already an existing aspect of any discipline’s practice as outlined by Haberstroh and colleagues (2014); (2) a second element relating to HIPAA that deserves its own discussion, since HIPAA also addresses the most concerning aspects of the first issue.

HIPAA

Prominent on all vendor pages will be the claim that their specialized technology is HIPAA compliant—that is, the technology meets the information security requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Rarely discussed is what constitutes HIPAA compliance. In sum, HIPAA compliance includes: having a Business Associate Agreement with the platform provider; SSL encryption across the website; a site that is password protected; and encrypted messaging, email, and videoconferencing systems. To the extent data is stored, this must occur on secure servers. These data must have routine automatic backups and periodic manual backups that comply with HIPAA guidelines for data storage and security. Finally, there must be processes for monitoring and auditing to ensure that HIPAA Security Standards are met.

One example illustrates concerns related to the use of Skype for TM practice. Specifically, it is not possible to sign a Business Associate Agreement with Skype. Even though communications are encrypted and data are not stored on their servers (except for chat messages), Skype is not legally obligated for any violations of protected health information. On the other hand, one does not have to pay exorbitant amounts for a HIPAA-compliant platform. The Telemental Health Institute (<http://telehealth.org/video>) provides information on several systems that have pricing options that start at less than \$100 a month.

Most importantly, practitioners should not cite technical costs or avoidance of HIPAA-related issues to practice ethically when it comes to privacy and confidentiality. Unfortunately, a study by Fornari-Spoto (2011), reported by Lemma and Fonagy (2013), indicated that 31% of psychoanalytic providers were conducting analysis via telephone and Skype. With the availability of relatively inexpensive software and consulting available for online practice, TM practitioners, and the organizations by which they are employed, are obligated to seek such services in order to preserve the integrity of the mental health profession.

TM PRACTICE SKILLS

Having considered the need for TM group practices, the modalities in which they can be delivered, the diagnoses and conditions most suitable for such interventions, the research

on efficacious outcomes, and the ethical boundaries in which practice must take place, the prospective practitioner already trained in one or more of the modalities will be ready for the next step: acquiring the technical skills to engage in such practice. Fortunately, many resources can be found online, and the literature continues to grow (see, e.g., Anthony & Nagel, 2009; Derrig-Palumbo & Zeine, 2005; Finn & Schoech, 2009; Kraus, Stricker, & Speyer, 2010). However, and most importantly, no amount of technical expertise will ever be able to substitute for being a trained group practitioner in the first place. If one does not have a thorough grounding in the nuances of group-speak related to stages of group development, then technology will be of little help.

Technology

One noticeable omission from most studies, with some exceptions, is a thorough description of the hardware and software used (see, e.g., Greene et al., 2010; Wade et al., 2004). More concerning was the relative lack of acknowledgement or awareness of how rapidly technological advances are occurring. This was most troublesome when study conclusions were made that sounded as if a technical solution could never meet the therapeutic demands. For example, Damianakis and colleagues (2008) reported that only one person at a time could be seen in their synchronous videoconferencing sessions. Carey and colleagues (2008), noted poor video quality as contributing to poor clinical outcomes. However, both of these studies were published in 2008. Today's technology easily provides the means for all participants to be seen, and video quality continues to improve with expanding broadband and wireless networks, so the limitations cited in these studies are now becoming much less frequent.

As noted, a quick glance at the date of publication provided all the information that needed to be known relative to their statements concerning technology. For example, one simply needs to remember when they made their own Skype or video call relative to the date of the article. With that frame of reference, we can better understand how some study conclusions are reached and/or how those same conclusions would look much different with today's technology (noting that "today" has become "long ago," technologically speaking, by the time this paragraph is actually read).

Similarly, the more ubiquitous technology becomes, the less we will be conscious of what it means to be TM. For example, Google Hangouts (www.google.com/hangouts) and Zoom (www.zoom.us), among many other software applications, provide free group videoconferencing platforms that work across a wide array of devices, including smartphones. I currently have students who do group videoconferencing on a routine basis in order to complete class assignments or projects. To introduce the notion of doing a group work session online would be completely rational and make perfect sense because technology users are already living within that technology context.

Procedures

As previously discussed, TM groups provide new ways for practitioners and members to understand, access, participate, and learn from each other. For example, if restricted to in-person group contact only, there is almost always time set aside for "housekeeping" issues related to meeting times, comings and goings, changes in routines, and so forth. With TM groups, these communications can now be conveyed via email at any time and as they arise between group sessions. Furthermore, exactly what constitutes a group session is not always straightforward. TM "synchronous" groups most closely align to the traditionally

understood group session because there is a set time each week when everyone is expected to meet, either via chat or videoconferencing. However, even these group members can receive emails during the week if the need arises.

Asynchronous groups present a different perspective on the group session. Generally, a “session” runs on a week-to-week basis, with all activity occurring through a discussion forum in which members are expected to respond to a practitioner’s posts and/or other members’ posts. Time guidelines are typically suggested for these posts, but it is generally understood that deadlines run on a week-to-week basis.

In this environment, email communication between practitioners and members and members among themselves is an emerging phenomenon that cannot be tightly prescribed until additional research is done in this area. For example, Berger and colleagues (2009) found in their anonymous online group forum that the participants had the “time” to share their experiences, stressful situations, and experiments with new behaviors that cannot fit a traditional F2F group time slot. In addition, the group members spent more time conversing with each other than with the practitioner, as one would expect when a group is “working.”

Another practice assumption that needs to be addressed in training, especially regarding synchronous videoconferencing with family groups, is the control over environmental issues that cannot occur in family settings. For example, an office setting provides a controlled space, with noise and other distractions kept to a minimum. Such is not always the case when doing a family intervention with videoconferencing (Gilkey et al., 2009). Although some may view it as a compromise to the intervention, Gilkey and colleagues (2009) thought the videoconferencing afforded the opportunity to view the family in a setting more naturalistic and comfortable for the family and revealed communication patterns that most likely would have been tempered in a formal office setting.

Despite the time savings that can occur from using technology, it is absolutely imperative that time be set aside to train all participants in technology use. People who do not use technology on a regular basis, or if not provided adequate support, are less likely to benefit from TM interventions (Carey et al., 2008). As outlined by Damianakis and colleagues (2008), Gilkey and colleagues (2009), Wade and colleagues (2004, 2006), and others, it is typical to spend 1–2 hours alone on how to use the technology, access the web-site, navigate the website, and learn the tools and features within the site.

Included in this training time will be exposure to the treatment manual or materials and how to use them and print them if needed, and also how to communicate with the practitioner if questions arise. Furthermore, reaching out to clients midway through an intervention—for example, during week 4 of an 8-week intervention—*before technical issues arise* can go a long way in making sure the technology does not hinder the therapeutic alliance and compromise overall outcomes. Done properly, and as found by Damianakis and colleagues (2008) and others, even the elderly and those without prior technology experience can learn to use these new tools and achieve positive outcomes.

FUTURE DIRECTIONS

Before specifying future research directions, three studies should be noted that had a surprising and concerning outcome for those who practice in traditional F2F settings. Andersson and colleagues (2013) compared a well-established in-person CBT group therapy intervention for depression with an online, self-paced, individually delivered text-based CBT intervention. While both treatment groups displayed large positive effect sizes, the online

CBT intervention showed larger effect sizes at a 3-year follow-up. Similar findings were reported by Hedman and colleagues (2014) for a social anxiety disorder CBT intervention in which participants had weekly email contact with a practitioner who guided them through online delivered modules compared to an F2F CBT group. Not only were significant clinical outcomes maintained at the 4-year follow-up, but the cost-effectiveness favored the TM intervention over the F2F group. Similarly, Preschl, Maercker, and Wagner (2011) found no significant differences in the ability to form a working alliance between a traditional F2F group and a practitioner who provided an online CBT intervention for depression on an individual basis. The ramifications are obvious: due to all the previously discussed barriers to accessing traditional in-person group services, if clinicians know that issues can be treated more expediently through an Internet-delivered intervention at the client's convenience, then the number of recommendations to F2F group work may decline.

Therefore, while research clearly indicates TM groups to be effective, how and why they are effective needs additional research, especially if TM group practice may now need to compete against TM individual practice and F2F practice in general. Specific research questions in that regard will include: Which types of clients are best suited to receive group therapy services online? What kinds of support do they need before, during, and after receiving services? Which therapeutic modalities are ideally suited for online delivery? Of those, how is it best done—synchronous, asynchronous, augmented with email or telephone, or some other way? How can attrition rates with TM groups be modulated?

While some of the reviewed studies had attrition rates over 25%, other studies had attrition rates that approached 0% and/or were comparable to F2F practice. Why was that? What is the best way to train clinicians to operate with this medium? How should private practitioners, counseling agencies, and public agencies restructure their programming to accommodate a modality that may conflict with existing business models? How do clients, practitioners, agencies, and accrediting bodies deal with constantly evolving technology capabilities? Finally, and underlying all of these questions, is the need to delineate theoretical frameworks that can account for the relationships between all of these issues. None of the 173 articles reviewed since 2005 had a clearly articulated theory that operationalized the nexus between the technology and the therapeutic modality.

Admittedly, these questions assume that TM groups are a good avenue to pursue. However, the answers to these questions must also take into account any unintended consequences that may arise from their use. Because they are unintended, there is no way to know what those may be at this time. Nevertheless, there is no reason to believe that unintended consequences will not occur; thus the use of TM groups moving forward must be done in a judicious manner by practitioners who are willing and able to note all outcomes regardless of intent.

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Epilogue

CHARLES D. GARVIN
LORRAINE M. GUTIÉRREZ
MAEDA J. GALINSKY

In this volume we intend not only to report what is already known but also to stimulate the development of the theory and practice of social work with groups. One of the most important ways in which this happens is through the creation of practice theory and practice research, and we believe these are inextricable.

PRACTICE THEORY

The focus on evidence-based practice in social work has been discussed at various places in this volume—practice grounded in the best available research evidence and integrated with practitioner wisdom and consumer preferences. There are differences among writers as to how such evidence is used, either as a *requirement* for employing an intervention or as a *guide*, applied with judgment and flexibility, for action. Our own use of practice theory, and its presentation in this book, has been broad, and the authors, as a consequence, have applied a large number of practice principles to a wide variety of situations. They have drawn from social science theory and research about group norms, group goals, group development, and other aspects of group dynamics and have utilized such concepts as group composition, mutual aid, and group activities. We and the authors have also considered system levels and the interactions among them, such as group–agency–environmental interactions. We need to continue these efforts, including generating descriptive accounts of group work, as well as adding to a growing body of empirical literature.

An important aspect of our ability to meet this challenge is the growing acceptance by group workers of the need for theoretical specificity and specification of practice principles, as well as a recognition that there is not one all-purpose theory to which every group worker must adhere, no one overarching model of practice.¹

We must always be ready to ask what works with a new population. What are the worker actions that are most helpful to provide support, to accomplish organizational tasks, or to enable intrapersonal change? What kinds of curricula-oriented procedures can we recommend for a particular problem or task? How do we develop recommended formats for either open-ended groups or groups with a preestablished agenda? How, exactly, does the context affect the delivery of group services?

Writers on group work are increasingly providing explicit principles for different aspects of practice. They are developing practice manuals rooted in social science, as well as in group work practice and research. We are mindful, moreover, of a recent article by Gitterman and Knight (2016), who present a thoughtful discussion of how to draw upon such manuals while committed to principles of social work with groups. Consistent with this article, the authors in this book, when they refer to manuals, often indicate that they are resources to be employed not rigidly but in ways that recognize that members of one group differ from those of another and are likely to set in motion processes that should be understood and respected by practitioners. Thus any structured approach to practice must be used with full recognition of the wishes and inputs of members.

As we work to improve and build upon our practice theory and to strive for increased specificity about what we do, we encounter a series of issues. Topics here include the degree of flexibility in the use of practice principles and the necessity to review and update practice principles and to engage in culturally competent practice. Specificity is a desirable quality, and practice should be based in accumulated knowledge. However, in view of frequent lack of data and because practitioners seek to understand the distinctive qualities of each group, they will have to make choices and exercise judgment, to assess unique individual and group factors, and to build on their own experience. Furthermore, evidence-based practice should reflect that member choice is an important consideration for worker action.

Because of the complexity of human behavior and the many ways in which practice situations vary, we may never be able to develop directives that fit all practice situations. Thus there is an art in the application of practice guidelines. Group workers must engage in critical thinking. They must have a broad theoretical perspective, be aware of specific practice principles developed from research evidence, and consider the uniqueness of each practice situation. They also should take into account their own practice experience, as well as incorporating member wishes.

A major challenge to group work in the coming years will be to make appropriate use of technology, and we have included a new chapter on this subject. We continue to see growth in the ways group workers make use of technology, such as text messages and employing Skype to facilitate communication among members.² Skype enables a member who cannot attend a session in person to participate via the Internet. (One of us [C. D. G.] “attended” a men’s group in Michigan of which he was a member, even while he spent a winter in Florida.)

A second important issue is to keep our practice guidelines up-to-date. Ideally, a book such as this should be revised every few years, and we apologize for the decade it took before we did this.

A third important issue is an emphasis on cultural competence—the relationship of group work in practice (and in practice theory) to diversity. We need to recognize oppression and privilege as they relate to both members and workers, as well as to the agency. Recently, group workers have been becoming familiar with the concept of critical intersectionality, in which people are not seen as fragmented by their various identities, such as gender, age, ethnicity, and sexual orientation. Rather, they are seen as a whole as determined by their sense

of themselves and the realities of the larger society. For example, Asian women may not be viewed at one moment as Asian and another moment as women but in the ways that society and significant others view this set of identities. Practice principles for cultural competence must also be built on an empirical foundation, and the practitioner should seek information from a variety of sources regarding the impact of culture.

PRACTICE RESEARCH

As we have emphasized in many places in this volume, and especially in Part VI, we must continue to create a strong empirical foundation for group work. This effort directs the practitioners to continue to develop their ability to understand research findings, to evaluate the validity of the research, and, where possible, to engage in research either by themselves or collaboratively with researchers.³ The research-related issues on which we must work are: (1) the training of group work researchers; (2) the development of appropriate research methods; (3) the nurturing of research–practitioner partnerships; and (4) the translation of research findings into language that communicates with practitioners. The scope of this research agenda calls for a broad range of research approaches, including qualitative and quantitative methods, ethnography, experimental research, and community-based participatory action research.

This volume includes updates of chapters from the first edition that dealt with some of these approaches, and we have added a new chapter specifically devoted to qualitative research. We also urge the appropriate use of intervention research (in which findings are immediately applicable to practice), and this volume has a new chapter on that topic.

We need to build a cadre of trained researchers who are committed to studying group work processes and outcomes. We should create a climate in which an interest in testing and examining practice principles is valued and rewarded. A good basis for this is the International Association for Social Work with Groups Standards (2006); the standards themselves have been the subject of research (Macgowan & Vakharia, 2012).

Another task in the empirical sphere relates to research methodology—design and measurement issues—and several chapters in this handbook focus on it. We need to create research designs that capture real-life practice situations and that also give us a valid assessment of effectiveness. We should go beyond practitioner descriptions and subjective evaluations to well-developed ethnographies and well-formulated evaluations. We should also test our interventions in several sites. Researchers should be trained in *both* quantitative and qualitative methods and to know which method or combination of methods to employ to answer the research questions (such as the best use of comparison and wait lists when we cannot reasonably randomly assign participants to experimental groups).

Measurement tools to study group processes and outcomes should continue to be developed, as suggested in Chapter 30. We need more validated measures to adequately capture the processes that occur in relationship to worker actions. Although the currently available measures may at times be adequate to this, other measures, especially related to mutual aid, should be further developed.⁴

Another issue is that of the types of collaboration between practitioners and researchers. Participatory action research is one model to accomplish this. In this model, practitioners (and members) are involved in all stages of the research process, such as the choice of research questions, the selection of research sites, the choice of a research methodology, the conduct of interventions, the evaluation of processes and outcomes, and the interpretation

of findings. Practitioners have a responsibility to help create a hospitable climate for intervention research by participating in the research, following the agreed-upon plan, cooperating in the collection of data, engaging in interpretation of data, and, of course, utilizing the findings in their practice.

Researchers also have a responsibility to translate findings into language accessible to practitioners. Researchers sometimes complain that practitioners do not pay attention to research. It is essential, therefore, that they articulate the implications of their findings for practice in a usable form.

Although the focus of intervention research has often been in clinical settings, our suggestions are equally applicable to groups in organizations and communities. The use of groups in these settings is widespread, and chapters in Part V of this book stress this. An important challenge for the field of group work is to continue to develop research-based group methods for such work.

Researchers may also not adequately appreciate practice wisdom. Much could be gained by interviewing workers and identifying such knowledge for dissemination, as well as for generating research.

To summarize, the areas of challenge we have addressed and to which we hope this volume contributes are (1) the use of technology in group work practice; (2) development of specific practice theories for groups used with different populations; (3) enlargement of the empirical base for practice; and (4) strengthening the relationship of practice to the attainment of social justice.

We believe those of us in practice and those of us in research can work together to meet these challenges. We can flourish in an environment that supports both the group work practitioner and the group work researcher, that respects the worlds of practice and of research, that encourages interchange, and that values what each person has to bring to the pursuit of effective group work practice. With a spirited devotion to practice and to research, we believe group work can meet the challenges of expanding the scope of practice, tackling new problems that emerge in the world, and contributing to social justice.

NOTES

1. Perhaps one caveat on this statement, however, is for practitioners to adhere to the social work Code of Ethics when they choose what to do in various situations (National Association of Social Workers, 2008). Group problem solving in a task group is not identical to that in a therapeutic group. Group work with an open-ended group is not the same process as group work with a time-limited group. Group work through an electronic system (e.g. telephone, computer) is not the same as group work face-to-face. And community empowerment and social action groups do not use the identical procedures as support groups in a hospital setting.
2. Skype is a computer program that allows people to see and hear each other as part of its technology.
3. One of us (C. D. G.), together with several contributors to this handbook, have written the first volume we know of that deals with how social workers with groups can do research (Garvin, Tolman, & Macgowan, 2016).
4. Currently, members of the practice committee of the International Association for Social Work with Groups have been holding sessions at the annual symposium of the association, as well as between meetings, to secure funding for such a project.

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