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INTRODUCTION

This book describes six group therapy approaches that are appropriate for use in hospitals, partial hospitals, and residential treatment centers. The broad scope reflects changes in group therapy practice in the 25 years since our last book with this general focus was published (Brabender & Fallon, 1993). Since then, the number of models available to the practitioner has increased substantially, and practitioners today may be practicing in settings beyond the inpatient group, namely, partial hospitals, and to a lesser extent, residential treatment settings. The latter sites have emerged more prominently with the decrease in inpatient psychiatric admissions as societies have moved in the direction of health care that is more affordable. By presenting an array of models, we hope readers will see that tremendous variety does exist and will find one that fits their practice settings, the populations served, and their theoretical and technical proclivities. Our aim is to provide

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beginner or midcareer therapists as well as seasoned group psychotherapists with approaches or elements of approaches that will catalyze their group work in a way that makes it more fulfilling and more effective.

IDENTIFYING OUR FEATURED CONTEXTS

The expansion of models is a felicitous development because settings vary widely from one another. We firmly believe that the optimal model a practitioner uses is often not the model encountered during his or her graduate school training or the pet model of a past supervisor. Rather, our view is that the model that will be successful is the one that meshes especially well with the treatment environment. Although this point might appear to be a truism, it is our strong impression, and the research (e.g., Farley, 1998) suggests, that model–context compatibility typically receives little attention in clinical environments and professional training.

The private practitioner who is developing a group has a great deal of control over many variables—where the group will meet, at what time, how many times, and so on. In other words, the private practitioner can select a model and develop a context that will be compatible with it. The group therapist intending to conduct a group that is part of a larger therapeutic program must accept many contextual features as a point of departure. For example, settings often define the time of a group or the duration of the session. The therapist culls group members from a defined population to which the program caters. In other words, the context must precede model selection. Of course, a feature that might be fixed in one setting might be malleable in another. However, overall, groups taking place in a larger treatment environment must be designed with a thorough consideration of context to be both viable and effective. In creating a contrast between groups in a treatment context and stand-alone groups, we recognize that the difference is a matter of degree. Sometimes a group therapist working in an inpatient setting will have a great deal of control over contextual features. It is not unusual for such control to increase along with one's tenure in an institution or organization. It is also true that a private practitioner will be limited by various factors such as the availability of certain types of patients in the community in which he or she practices. Nonetheless, in general, the group psychotherapist operating in a defined context has to give greater deference to context. In doing so, the group psychotherapist can experience the environment supporting his or her work. For example, a model that is comprehensible to other staff is likely to be supported by that staff, as in the case of an aide who notices an opportunity for a member to work on a skill being fostered in the psychotherapy group, on the larger unit, and encourages her to take advantage of it.

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The three therapeutic settings that we feature in our text are not the only instances of group psychotherapy in a defined context. Group treatments—for example, in prison settings, schools, and the military—occur in well-defined contexts. Indeed, some of what we talk about in this text applies to these groups, and occasionally we mention these settings. However, our emphasis is on groups located in a broader therapeutic context. The other types of groups have additional challenges and other flexibilities that we do not address.

SELECTING THE MODELS

Probably the biggest decision we had to make beyond the selection of contexts was the identification of particular models we would feature. This decision was challenging because group psychotherapists often combine elements of models and write about them in this fashion. For example, Burlingame, Strauss, and Joyce (2013) wrote about a recent trend in the literature on inpatient, day hospital, and residential groups for individuals with personality disorders, toward the integration of cognitive behavior therapy and psychodynamic theory. This trend is positive in that it represents the therapist's laudable effort to customize a model for his or her setting. Nonetheless, amidst so much variety in combinations and integrations, characterizing models in their pure form was daunting. Still, integrations require a full knowledge of the elements in their essential form; therefore, we felt the effort to undertake this task was worthwhile. Another consideration was our interest in having models with a breadth of application. Today, psychoeducational groups are often used in the settings we feature (see Chapter 2). However, typically, these groups are designed in relation to specific psychological problems and/or characteristics of the patient population. We were interested in models that were sufficiently general as to be applied to a range of human problems, regardless of whether members were formed into symptomatically homogeneous or heterogeneous groupings.

We were also interested for two reasons in featuring models that would have some capability for allowing a focus on process. First, a focus on process (the interactions between and among members and the therapist) is associated with more favorable outcomes. Second, a process focus establishes group psychotherapy as a unique offering in relation to the other formats (including psychoeducational groups) that are popular in treatment programs in the three settings. We believe that the contribution of group psychotherapy should be distinctive rather than duplicative.

Although a focus on group process was important to us, we recognized that some models, such as the interpersonal and psychoanalytic models, are

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better able than others to accommodate an exploration of process. Whereas interpersonal models focus on dyadic aspects of process, psychoanalytic models lend themselves to looking at process on a subgroup and group-as-a-whole level. We believe that by tapping some of the process elements in the interpersonal and psychoanalytic models, those models that are not naturally oriented toward process can be enriched.

The models we feature were chosen on several grounds:

- The presence of features outlined earlier in this chapter—a model of psychopathology, a statement of goals, and a specification of interventions. This requirement resulted in the exclusion of many contributions that simply proposed techniques or principles.
- The presence of some reasonable level of clinical interest in the model as reflected by the literature on groups over the past 20 years.
- The power of the model to be used in a range of settings and conditions. For example, we excluded from the text some interesting models created for specific diagnostic groups, such as inpatients with chronic combat-related posttraumatic stress disorder (e.g., Southwick, Gilmartin, McDonough, & Morrissey's, 2006, logotherapy model) or eating disorders (Dean, Touyz, Rieger, & Thornton's, 2008, motivational enhancement model). However, those familiar with these models may notice that they have important conceptual links with one or more models presented in the text.
- A breadth and contrast between models. We sought to include models that are highly varied regarding theoretical orientation, goals, techniques, and the demands they place on clinical settings. Once again, our intent here was to increase the likelihood that each reader—given the specificities of his or her setting, population, and person—could find an appropriate model.

We would be remiss if we did not acknowledge that our criteria for inclusion have some arbitrariness. If another team were attempting to organize the theoretical and technical contributions that have been made to group psychotherapy in the three contexts, they would likely have done it in a substantially different but equally descriptive way. This same point applies to our placement of the contributions of various writers in one model category or another. Some writers have ties to a variety of models, and we have endeavored to distill the major emphases of their writings.

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SELECTING OUR TARGET AUDIENCE

In presenting the models, we recognized that our target audience is likely to be diverse. According to feedback on the text on which this current book is based (Brabender & Fallon, 1993), we expected that many students would read our book. Students commonly find themselves placed in inpatient hospital programs (IHP), partial hospital programs (PHP), and residential treatment centers (RTC). Often, they are asked to lead groups and are given little direction on how to do so. It is our hope that this book would provide a point of departure for thinking about the group they would like to conduct. To meet students' needs, we provide a fair amount of background on theory and mechanics and do so with the knowledge that many students will enter a placement situation without having had a prior course in group psychotherapy. Of course, if students use our book in this way, we would want them to obtain supervision from a qualified group psychotherapist as they are pursuing their group work. Some students might encounter our book in a graduate course. We have designed the clinical illustrations so that students could act them out in class—an experience our graduate students and psychiatric residents have found to be both edifying and enjoyable.

We also anticipated that our book would be of use to more experienced group psychotherapists who either are finding themselves in one of the three treatment environments for the first time or are interested in learning about new approaches. We recognize that for these group psychotherapists, we probably provide more detail on basic theory and mechanics than is necessary. We invite such readers to adjust how they read the book to their interests and needs.

ROAD MAP OF THE BOOK

Broadly, in the ensuing chapters, we discuss contexts, models, and the interrelationships. In Chapter 1, we argue for the importance of a model framework and delineate the settings that are the scope of this book. In Chapter 2, we characterize the major important contextual dimensions that distinguish one treatment environment from another. All of the dimensions we mention are those that are likely to affect model selection. We then have a set of six chapters that describe the models themselves.

We sequenced the models from the most to the least process-oriented. The first model (Chapter 3) is the popular interpersonal approach, to which most practitioners gain exposure through the writings of Irvin Yalom (Yalom & Leszcz, 2005). Even neophyte practitioners are probably

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at least somewhat familiar with Yalom's (1983) highly structured versions of an interpersonal approach, which have been applied in many IHP, PHP, and RTC venues. However, in other sites, a more unstructured version can be implemented primarily because of the greater length of group participation. We also cover interpersonal therapy–group (Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000), which is loosely connected to Yalom's writings but has also been influenced by other theoretical strands. Our chapter aims to capture the richness of all of these contemporary interpersonal applications.

The next chapter addresses the family of psychodynamic models (Chapter 4). Today, an array of psychodynamic models exists that takes into account the realities of contextual group psychotherapy, such as the often-short time frame and the severity of members' pathology. We begin with a consideration of what makes a model psychodynamic and then explore different ways that psychodynamic principles have been used in IHP, PHP, and RTC contexts. We look at a model of group psychotherapy that centers on members' object relations (or internal representations of self and other). The object relations/systems or Kibel (1981, 2003, 2005) model is especially popular in Western Europe. We also describe a newer model that seeks to promote mentalizing in group members (Karterud & Bateman, 2012) to support affect regulation and the development of a cohesive sense of identity.

We then proceed to the cluster of cognitive behavioral approaches (Chapter 5) to contextual group psychotherapy. Increasingly, cognitive behavior therapy (CBT) approaches have drawn on some of the process elements described in the prior two chapters. In the 1980s, the cognitive behavioral approach began as a treatment method for outpatients. Freeman, Schrodt, Gilson, and Ludgate (1993) extended it to the inpatient context, and it continues to garner interest in IHP settings (e.g., Forsey, 2013). More recently, group psychotherapists have developed their applications for PHPs (Neuhaus, Christopher, Jacob, Guillaumot, & Burns, 2007) and RTCs (Armelius & Andreassen, 2007). This chapter also covers schema-focused therapy (McGinn & Young, 1996), which has become an extremely important variation of the cognitive behavioral approaches to group therapy—including IHP, PHP, and RTC—since the publication of our 1993 book. A model that represents a subarea of CBT is dialectical behavioral therapy (DBT; Linehan, 1993). DBT is a highly combinatorial form of treatment, borrowing elements from various schools of thought. Applications of DBT have been developed for IHPs (e.g., McCann, Ball, & Ivanoff, 2000; Swenson, Witterholt, & Bohus, 2007), PHPs (e.g., Simpson et al., 1998; Yen, Johnson, Costello, & Simpson, 2009), and RTCs (e.g., McCann, Ivanoff, Schmidt, & Beach, 2007).

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The next two chapters present models that are increasingly established in their own right but have a strong connection to CBT both historically and conceptually. The acceptance and commitment therapy model devised by Hayes (2004) is the focus of Chapter 6. Although this model has many similarities to DBT, it also is distinctive in its greater stress on reducing experiential avoidance and fostering radical acceptance of the full gamut of psychological experiences so that individuals can act in accordance with their goals and values. It shares with CBT and DBT applications the presence of considerable empirical support with the patient populations found in IHP, PHP, and RTC settings.

We then move on to the skill-based interpersonal problem-solving model (Spivack, Platt, & Shure, 1976; Chapter 7) for the treatment of a wide range of psychological and physical problems, which remains the object of considerable empirical inquiry. A strength of this model is its breadth of application with individuals at different levels of ego functioning and its use with children, adolescents, and elderly patients. The last model we present is the social skills training model (Chapter 8), which continues to be used to treat the most severely disturbed patients (e.g., Frey & Weller's [2000] program to treat aggressive behaviors in psychotic and mood-disordered state hospital patients). It is the most concrete of the models presented in this volume and provides the most scripted approach to examining the interactions among members. This model is particularly suited to work with extremely low-functioning group members, although it accommodates a wide variety of presenting problems.

In our final chapter (Chapter 9), we perform a comparative analysis of all six models. We seek to aid the reader in finding a useful model for his or her setting. We reiterate a theme of this book, which is that model selection should be predicated on as much knowledge about the setting, the population, and the therapist as possible. We also underscore the point that we made many times previously that model selection is never a final step because all settings have a uniqueness that must be accommodated for the fit of the model to be optimal. Once this customized model is applied, we stress, it should be continually scrutinized to ensure that it is serving the treatment needs of group members.

In those chapters devoted to the presentation of models, the reader will find that we use a fairly consistent outline. Generally, the topics flow as follows: theoretical suppositions, technical considerations, illustrations, research on the model, contextual requirements (or demands), and a summary. Where we deviate from this order, we do so to accommodate some of the unique features of the model (e.g., we might create a section for a topic covered in the present model but ignored in the others). The illustrations of group sessions are examples of identified therapeutic approaches

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conducted in specific settings. The patients, their described problems, and their interactions with each other are fictitious composites of the thousands of patients that we and our students have worked with over our decades of clinical work and supervision. They were developed to represent the kinds of populations, problems, and interactions that are likely to occur in each of these settings with the specific model presented. Every setting is unique and every group a different experience. The examples illuminated are successful ones, although we are the first to admit that not all interventions work this well. We, at times, have been humbled by our flops and spurred on by our successes while leading psychotherapy groups. The group therapist may find that his or her context requires a group approach that is in need of considerable fine-tuning and modification to achieve positive results. We encourage the group therapist to recognize that it is a process that is worth the effort.

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