

CHAPTER 1

Introduction

In Western cultures, we tend to see ourselves as separate from others—as individuals first and only secondarily as members of groups. We learn to think and act on our own. We carry our family's surname but typically consider the successes and failures we experience in life as our own, not as products of our families, networks, and communities. When we describe ourselves, we mostly use individualistic terms rather than the interpersonal descriptors more commonly used by those in non-Western cultures, such as societal roles or membership in cultural or ethnic groups (Triandis, McCusker, & Hui, 1990). Even our models of ourselves are individualistic, including concepts such as separation and individuation to signify appropriate psychological maturation.

In this context, most of the helping services we offer are individually oriented as well, focused on the challenges and opportunities of individuals, and interpreted through a lens that focuses on individuals' characteristics, dysfunctions, or pathologies. Even strengths-based approaches focus more on individual strengths than on interpersonal opportunities or supports.

Although we may see ourselves as separate, we are inextricably linked to others in groups. Our species evolved through the support and protection of the group. Our identities are shaped by the feedback we receive from family, peer, and social groups, as are our thoughts, decisions, attitudes, and values (Forsyth, 2011). Working together, we accomplish more, because the diverse knowledge and skills of the entire group can benefit each individual. Thus, most of us work with others; join others in families, friendships, peer groups, and communities; and rely on society to provide us with access to shelter, food, and other necessities. We rely on groups for many aspects of our existence, because groups can do for us what we cannot always do for ourselves. When we align ourselves with supportive groups, we are less stressed, less lonely, and we have greater self-esteem, are healthier, and may even live longer (Forsyth, 2011).

In recognition of the power of groups, therapeutic services have been developed for couples and families, as well as groups created solely to enable people to achieve together what they may struggle to achieve on their own. More than just serving as efficient delivery mechanisms, group services offer benefits that individually based services cannot provide. In therapeutic groups, members provide each other support, understanding, enlightenment, protection, and the opportunity to grow through contributing to the growth of others.

Group services are more complex than individual services. In a dyadic interaction, there is one relationship between two individuals. By adding a third person, there become seven possible relationship configurations (three one-on-one relationships, three one-on-two relationships, and one whole group relationship). With a group of only four people, there are 25 combinations of possible subgroup relationships, in addition to the group as a whole. As groups continue to grow in size, the potential relationships and subgroups for leaders to track and attend to increase exponentially, requiring leaders to develop high sensitivity in order to build upon subtle interaction patterns or minimize their influence on the group as a whole, whichever is appropriate.

Group services are unable to give individuals as much direct attention and floor time as individual services, and there are group processes that can inhibit or even hurt. Given the potential for both harm and benefit from subgroup relationships in therapeutic groups, careful adaptation of services initially developed for individuals is necessary to capitalize on possibilities and minimize potential problems.

Motivational interviewing (MI) has been developed as a client-centered, goal-oriented, individual therapeutic approach. MI focuses on client perspectives rather than framing issues from a professional viewpoint. Practitioners avoid directing clients toward specific solutions in ways that may elicit resistance. Instead they evoke clients' own interests in change and steer the conversation toward commitment to specific actions that lead toward clients' change goals, using the four general processes of engaging, focusing, evoking, and planning to achieve these aims (Miller & Rollnick, 2013).

MI focuses more on client perspectives than on framing issues from a professional viewpoint.

MI is a descendent of Rogerian client-centered therapy and has a humanistic orientation. From this perspective, people are naturally inclined to pursue growth and wellness. The role of the practitioner is to help them to more clearly sort out what they believe and who they experience themselves to be, not by providing education, but by helping them feel more comfortable with who they are and hear their own voices more clearly.

Practitioners view clients positively, accepting and embracing them as the unique people they are. By reflecting an accurate view of who clients see themselves to be, along with optimistic reflections of their strivings toward growth and their ability to become who they want to be, client-centered helpers assist clients in moving forward toward more fulfilling lives, while not attempting to set a particular path for them. As clients become more who they truly are (vs. being constrained by the limiting things they have been told about themselves), they begin to perceive and act in different, more congruent ways.

MI also has roots in behavioral therapy and the behaviorist tradition. From this angle, people's behaviors (and thoughts) are identifiable, measurable, and can be influenced toward more positive or useful patterns. By helping people identify (and track) unproductive patterns of thinking and acting, practitioners help them to establish and maintain more productive habits or patterns. Thus, behavior therapy helps people become more clear-minded and purposeful in living.

MI integrates elements of humanistic, client-centered therapy with those of behavior therapy—deeply valuing people for who they are while helping them identify specific ways they'd like to change and develop plans to implement those changes. MI practitioners talk with clients about the aspects of their lives that are dissatisfying and the ways that they'd like things to be better. They honor clients' ambivalence about making changes and strategically focus on those elements that provide momentum for positive change. They then help to develop plans that clients feel confident about implementing.

This book adapts the evidenced-based practice of individual MI to group format by integrating MI and core group therapy concepts into coherent MI groups. The model benefits from the ideas of colleagues working alongside us in this venture as practitioners, developers, and researchers, and those who have previously written MI group treatment manuals or descriptions (W. G. Anderson, Beatty, Moscow, & Tomlin, 2002; Beatty & Tomlin, 2002; Ingersoll, Wagner, & Gharib, 1999; Krecji, 2006; Murphy, 2008; Noonan, 2001; Velasquez, Maurer, Crouch, & DiClemente, 2001). We also integrate our understanding of MI with our group leadership experiences and the evidence-based recommendations of other developers and researchers in group therapy and the positive psychology movement.¹

¹While MI is not a part of the positive psychology movement, we have drawn significant inspiration from positive psychology and have integrated ideas from it into the MI group model presented in this book. Like Peterson (2006), we see positive psychology and humanistic psychology as close relatives, with more similarities than differences. MI incorporates elements of humanistic, behavioral, social, and cognitive psychology, and its proponents are fully committed to the scientific study of MI, as well as to updating the approach as conclusive findings accrue.

Groups at an Impasse

Before exploring what MI groups are, it may be useful to consider some challenges in providing group services that may be helped by incorporating MI concepts and strategies. Consider the following four scenarios.

Diabetes Support Group

A nurse and dietician facilitate a semimonthly diabetes support group. Although they facilitate group conversations in tandem, each has a specific focus. The nurse makes sure that participants understand the normal physiological processes of the kidney and pancreas, how disease interrupts these processes, and the appropriate use of insulin to compensate for the body's inability to manage insulin levels in a healthy fashion. The dietician focuses on managing insulin levels and overall health through careful and deliberate eating habits, and on making specific lifestyle choices regarding exercise, sleep, and alcohol use. As this is intended to be a support group, they also facilitate discussions about difficulties that patients experience. Because they are not trained as counselors, however, they ask group members to keep the discussion focused on specific difficulties in managing their illness, and they regularly steer the conversations back to this focus when members veer into more personal or emotional topics. Members were initially highly tuned in to the discussions, but over time their involvement seems to have diminished, and fewer attend each meeting. The leaders are unsure what they might do to reenergize the group.

Cognitive-Behavioral Therapy Group

A psychologist and an intern lead a group with a cognitive-behavioral focus for members who are struggling with anxiety. The group is well-structured, teaching members to identify cognitive errors, to become more aware of their automatic thoughts and internal dialogue, to do functional analyses, and to make behavioral plans. Group members regularly express that the cognitive-behavioral model helps them make better sense of their lives and possibilities. Still, week after week, only a few complete homework assignments, despite their continued confidence that next week will be better.

Addiction Psychoeducational Group

A substance abuse counselor runs an intensive outpatient group focused on interesting members in recovery and helping them rebound from relapse, using a psychoeducational approach with instruction, handouts, and practice exercises. The counselor's engaging, informal, and supportive style is

sometimes blunt and direct when participants disown responsibility for their difficulties or paint a prettier picture of their lives than reality may support. Some members confront others on their attempts to manipulate the group into supporting their unhealthy perspectives, and others offer practical advice based on their own experiences and things they have learned from community support groups. One thing these group members have in common with the counselor is a belief that people need to admit their problems and accept some truths about being an alcoholic or an addict. Other members doubt that they are truly addicted, and point toward the ongoing struggles of those who identify themselves as addicts as proof that “it’s not much help anyway to knock yourself down or call yourself names.” One member believes that Alcoholics Anonymous (AA) is a brainwashing religious group that is “almost cult-like.” Group members continue to struggle with each other and conversation reaches a standstill, prompting one member to reflect, “Sometimes it seems like a combat zone in here.”

Process-Oriented Psychotherapy Group

A social worker conducts a process-oriented psychotherapy group in which members are encouraged to focus on issues that are important to them and to use the time to define their own perspectives, identity, and values. Several members have identified specific issues on which they want to work, and a few already have focused on certain changes they want to make. Others who are not sure what to focus on just know they are not happy and feel like something is missing from their lives. The group runs smoothly and is never at a loss for conversation. The group leader skillfully reflects member perspectives and facilitates greater depth of dialogue. Members speak openly during the sessions, sharing useful feedback and support. A few months into the weekly sessions, however, a few members begin to question whether this is “all there is” to group therapy. A feeling of discontent seems to settle over the group. Conversations seem to go in circles, and a few members express frustration that others just complain about their lives rather than do something to make them better. The group leader affirms both the honesty of those who are frustrated and the autonomy of those who are targets of complaints in order to lead all members to define their own perspectives and goals for therapy. Still, the group seems to have reached an impasse, and the leader decides to consult with a colleague for input.

How MI Might Help These Groups

MI has something to offer to each of these groups experiencing a therapeutic impasse. In the diabetes support, cognitive-behavioral therapy (CBT), and

recovery group examples, the group facilitation is more counselor-centered and directive than is typical of MI groups. The psychotherapy group uses the client-centered style, but the facilitation is closer to nondirective following than to guiding. The MI combination of client-centered attitudes and goal-oriented processes can help establish momentum toward positive change, while avoiding some of the pitfalls of becoming overly directive or nondirective when leading a group.

In the diabetes group, knowledge of MI might influence the leaders to reduce the amount of information they provide to improve retention of the key facts members need to know to manage their illnesses. Instead of providing copious information, they might elicit what members already know, then “fill in the blanks” where there are gaps in knowledge, while helping members personalize health information to their own lives. This eliciting approach helps members better focus on their own important changes and can make sessions more interesting as discussions rather than lectures. MI may also help the leaders be more comfortable working with a broader array of life issues, that may indirectly relate to the goal of managing diabetes. By attending to related issues, while remaining focused on health goals, these practitioners can weave change strategies into the broader fabric of patients’ lives.

In the CBT group, cognitions and behavior seem disconnected. The group members see how the CBT model can help them understand their problems and provide strategies for reducing those problems, yet they don’t seem to use the model to change things. Incorporating MI strategies might help members “back up” a bit. Before they prompt members to implement changes based on the CBT model, the leaders might spend time eliciting members’ goals, hopes, and values, helping them envision a more satisfying future and connect to goals they want to achieve, then return to examining dysfunctional cognitions, only now with greater clarity on how these thoughts and reactions get in the way of achieving their goals. In this way, MI strategies may help members see connections between their specific thoughts and behaviors, and their more general hopes and wishes. When members perceive that CBT strategies not only address problems in perceiving and thinking but also help them lead happier lives, their investment in doing homework will likely increase, as they come to perceive homework as a helpful step down a more fulfilling path.

Another issue is that members see the leaders as experts who teach the group about thinking errors and ways of analyzing behavior. This tends to reduce the extent to which group members talk to each other or feel committed to each other’s growth and development. By adding thematic linking of similar issues, thoughts, and behaviors through reflecting these on a “meta” level, the leaders can increase group cohesion and the likelihood

that members will see themselves as drivers of change rather than as mere passengers.

In the substance abuse group, the leader has taken a stance on issues that cause ambivalence for group members. Because some members have ambivalence about the traditional recovery model, when the leader argues for one side of ambivalence they naturally defend the other side. In taking sides, the leader has externalized the ambivalence that members experience and inadvertently split the group into two camps rather than focusing the group on individually tailored changes that members may achieve in different ways. MI practice would suggest that the group leader should elicit and explore members' ambivalence rather than argue against it. Additionally, MI practice would guide the leader to model acceptance of the idea that "many roads may take you there" so that group members feel safe in expressing their views and do not fear being attacked for being wrong. Thus, the MI spirit of partnership, acceptance, compassion, and evocation can become a core part of group interactions. This can lead to fewer conflicts, more support, and more excitement about participating.

The psychotherapy group has skilled client-centered facilitation by the social worker. What MI can offer this group is more direction. By adding directional strategies to already skilled empathic responding, the group leader could help members focus on doing in addition to being and guide them to move toward more fulfilling lives, while deepening their understanding of themselves and their peers.

While MI can help these groups avoid or move past their therapeutic impasses, no approach can eliminate every challenge or obstacle. Some impasses and conflicts perhaps shouldn't be eliminated even if it were possible, because they can lead to transforming a set of individuals into a more meaningful, cohesive working group. During these transformative moments, many group members find their voices and increase ownership of their own lives.

Challenges of Running MI Groups

Providing high-quality, productive group leadership is more difficult than providing individual services. There are more ways for things to go wrong, and it can be harder to set things right again once negative cycles begin. Rather than having only one client to help along a productive path, you must help many people make progress. This requires facilitating focused and productive interactions between members with different histories, beliefs, values, and communication styles, while simultaneously processing your own internal impulses to focus on some members more than others.

Group leadership is more difficult than conducting individual therapy. There are more ways for things to go wrong, and they're harder to fix when they do.

Given the challenges of running groups well, why should you consider groups at all? Although empirical support for MI groups lags behind that established for individual MI, the available evidence is both positive and promising. The evidence base is modest at present partly because MI groups are a more recent development than individual MI (and are still developing), and partly because groups are more difficult to research than are individual services. Some controlled studies show promise for MI groups, but it is too soon to determine how they compare to MI with individual clients.

While studies of MI groups are only about a decade old, group services have been a reality far longer. In many settings, groups are firmly embedded into the array of services offered, and this is unlikely to change, even without strong evidence to support their use. And MI groups may have several strengths that are more difficult to achieve in individual services.

Potential Advantages of MI Groups

One benefit of MI groups is that they reduce the social isolation of members and increase recognition of the universality of suffering (Yalom & Leszcz, 2005). Often people who are struggling feel as if they are alone, different, and less competent or worthy than others. This perspective robs them of both self-esteem and *self-efficacy*, the belief that they can successfully make changes. Groups can remedy these problems more directly than individual services, because groups bring people together to share concerns and support one another, increasing their hope and confidence. By “going through it together,” members inspire one another through their progress and successes, and without the isolation they might continue to feel in individual treatment.

Another potential advantage of MI groups is their flexibility. There are several complementary ways to go about translating MI to the group format, with different methods to achieve success across different settings and populations. Groups can be developed in context, adapted to members' needs and goals, and to the setting in which they are run.

MI groups may focus on support, education, psychological change or behavioral change. MI groups may incorporate different conversational strategies, depending on what is most useful in the moment. Thus, MI groups may help clients to consider things more broadly or deeply, to think ahead, to focus more narrowly on specific actions they can take, and to restore their

healthy defenses when sessions close. There are many options for running groups as they develop through their natural phases of engaging, exploring perspectives, broadening perspectives, and moving into action. Although some groups may meet only once and others have revolving sets of participants, we aim our discussion toward the prototypical group that involves a mostly consistent set of members over a period of time.

Our Hopes for This Book

While a body of supportive evidence about MI groups is still accumulating, we are impressed by the wealth of ideas and therapeutic innovation shared by our collaborators. The richness of MI group descriptions for many diverse concerns presented in later chapters will likely inspire further innovations. Additionally, we hope that this book encourages researchers to develop a more comprehensive knowledge base on MI group models. This process will extend our understanding of the possibilities of MI groups, offer guidance toward further adaptations, and pose new challenges regarding the ongoing practice of MI groups.

We hope this book is useful for a broad audience, including both those who do therapeutic work informed by MI and are considering expanding their work to groups, and those who lead groups and are interested in learning what MI might have to offer. We want the book to be helpful to those whose work is primarily psychotherapeutic in nature, and to those who work in professions such as health care and corrections, in which traditional psychotherapy may be tangential to their core missions. Thus, we have written a book that can be read sequentially or in piecemeal fashion, depending on readers' background and interests.

References

- Anderson, P., Beatty, J., Moscow, S., & Tomlin, K. (2002). *Exploring change group*. Portland, OR: West Interstate Clinic, Kaiser Permanente Northwest Region, Department of Addiction Medicine.
- Beatty, J., & Tomlin, K. (2002). *Engaging youth in treatment: Group and family curriculum*. Portland, OR: West Interstate Clinic, Kaiser Permanente Northwest Region, Department of Addiction Medicine.
- Forsyth, D. R. (2011). The nature and significance of groups. In R. K. Conyne (Ed.), *The Oxford handbook of group counseling* (pp. 19–35). New York: Oxford University Press.
- Ingersoll, K. S., Wagner, C. C., & Gharib, S. (1999). *Motivational groups for community substance abuse programs*. Richmond, VA: Mid-Atlantic Addiction Technology Transfer Center.

- Krecji, J. (2006). *Motivational interviewing group treatment in behavioral health settings*. Princeton, NJ: Princeton House Behavioral Health.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.
- Murphy, R.T. (2008). Enhancing combat veterans' motivation to change posttraumatic stress disorder symptoms and other problem behaviors. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems* (pp. 57–84). New York: Guilford Press.
- Noonan, W. C. (2000). Group motivational interviewing as an enhancement to outpatient alcohol treatment. *ProQuest Digital Dissertations Database*, Publication No. AAT9998849.
- Peterson, C. (2006). *A primer in positive psychology*. Oxford, UK: Oxford University Press.
- Triandis, H. C., McCusker, C., & Hui, C. H. (1990). Multimethod probes of individualism and collectivism. *Journal of Personality and Social Psychology*, 59, 1006–1013.
- Velasquez, M. M., Maurer, G. G., Crouch, C., & DiClemente, C. (2001). *Group treatment for substance abuse: A stages-of-change therapy manual*. New York: Guilford Press.
- Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Copyright © 2013 The Guilford Press