

# Functional Analytic Psychotherapy for Interpersonal Process Groups: A Behavioral Application

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## Abstract

This paper is an adaptation of Kohlenberg and Tsai's work, Functional Analytical Psychotherapy (1991), or FAP, to group psychotherapy. This author applied a behavioral rationale for interpersonal process groups by illustrating key points with a hypothetical client. Suggestions are also provided for starting groups, identifying goals, educating clients, and making use of FAP in beginning the group process.

*Key word descriptors: Group, interpersonal, behavioral, functional analytic, FAP*

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There are a wide variety of cognitive behavioral and behavioral approaches to group psychotherapy. Cognitive-behavioral groups are often developed for skills training and utilize practical interventions focused on coping deficits and changes in thinking (Fisher, Masia-Warner, and Klein, 2004; James, Thorn, and Williams, 1993; Rittner and Smith, 2000; Rohde, Jorgensen, Seeley, and Mace, 2004; Wilson, Bouffard, and Mackenzie; 2005). In their overview on group psychotherapies, Vinogradov, Cox, and Yalom (2003) suggest that behaviorally oriented groups are generally time limited and are characterized by the use of behavior modification techniques.

Behavioral or cognitive behavioral group therapies for process-oriented groups that focus on interpersonal interactions as they occur in group appear to be less common. Several writers have addressed applied behaviorism in the context of interpersonal group psychotherapy. Rose (1977) offers mostly structural and applied approaches to group psychotherapy. Flowers and Upper (1994) identify behavioral interventions that can be integrated in groups, and Hollander and Kazaoka (1998) suggest that while behavioral approaches generally involve practical interventions, most often little or no attention is paid to theoretical or conceptual issues.

It is my goal is to introduce a behavioral theoretical approach for interpersonal process groups through the application of Functional Analytical Psychotherapy, or FAP (Kohlenberg and Tsai, 1991). In doing so, I hope to root technical and applied interventions in a more theoretical framework than is often found in the literature. In order to illustrate this application, I provide a conceptual overview by illustrating FAP with a hypothetical client in a group setting.

## The Application of FAP to a Hypothetical Group Member

The framework for FAP is formulated on three functional classes of behavior: problems, improvements, and verbal awareness of functional relationships. It is also formulated on Five Rules, which are considered to be "suggestions for therapist behavior" (p. 24).

In FAP, the functional classes of behavior are identified as Clinically Relevant Behaviors, or CRB's. Problem behaviors are classified as CRB1's, improvements in client behavior are classified as CRB2's, and verbal awareness of these functional relationships are classified as CRB3's.

CRB1's often interfere with clients' abilities to make meaningful connections and participate in intimate relationships. They are always related to the client's presenting issue, and are discreet, specific behavioral instances of the presenting problem occurring in session. CRB2's are in session improvements of

client behavior and may be successive approximations of desired adaptive responses. CRB3's are clients' interpretations, statements, and reasons for relevant behavior.

### *Identifying and Targeting Clinically Relevant Behaviors (CRB's) in Group Therapy*

In the following example I have identified a hypothetical female client and attempted to elucidate the FAP approach with this client in a group setting. Suppose this client reports being lonely. She also reports difficulty finding adult friends, finding meaningful connections, and being truly heard. This client will be used throughout this paper to help the reader understand the application of a behavioral conceptualization of group process.

*CRB1's:* In a group session, the client talks constantly. The content of her speech is focused on detail and is generally a description of what she has done throughout the day. This client may initiate all group sessions. This behavior could interfere with her relationships with others because group members might perceive her as long-winded or boring. Thus, for this client, one of her CRB1's can be identified as talking without pausing and keeping the content of her speech on detailed information about daily activities. It would be difficult for other group members to engage in dialogue with this client, and they may begin to feel as if they do not have the opportunity to respond to her. Further, they may be unable to interrupt and may feel hopeless about engaging in further conversation with her. The result could be annoyance and resentment by other members who believe she is taking up unnecessary time.

*CRB2's:* An example of a CRB2 may be difficult to identify during the early stages of treatment as they are "typically not observed or are of low strength at those times when the clinical problem, CRB1, has occurred" (p. 19). In the beginning stages of group, this client may never pause or wait to hear input from others. An accidental pause may yield an opportunity for therapist intervention, which would hopefully eventually encourage the client to pause on her own (CRB2). This nonverbal gesture would allow other group members to engage and interact with her. It elicits conversation and the potential for making connections with others. It also gives her the opportunity to see if others are receiving what she is saying. If she fails to do this in all of her relationships, she will most likely maintain her sense of isolation reported as her presenting concern. As group progresses, additional CRB2's for this client may include talking about things that matter, such as relationships, and taking into consideration positive feedback from the group.

*CRB3's:* CRB3's are essentially the reasons clients give for behavior. An example of a CRB3 might be a statement from the client: "People call me a leaky faucet and sometimes I don't know when to quit. I think sometimes I talk too much but I try not to do it on purpose". As the treatment progresses, the client may begin to verbalize functional relationships between events and behaviors. For example, she may state that she gets really worried that she won't have the time to talk in a group setting. Thus, she talks a lot. She may say that she feels pressured to talk because she believes that other group members don't have much to say, or what they have to say is somehow not very important. She may reflect that she is actually frightened that no one really wants to hear what she has to say, so she fails to attend (CRB1 avoidance) to the facial expressions or nonverbal behavior of other group members.

Yalom (1995) speaks to the significance of CRB3's by suggesting that reasons clients generate for their own behavior results in a sense of mastery and freedom. He suggests that generating reasons provides motivation for understanding, identifying, and controlling the unknown. He suggests it is an essential aspect of the change process because it moves people from a "passive, reactive posture to an active, acting, changing posture" (p. 171). If clients are able to articulate how their behavior functions in their life they can acknowledge areas in which change is needed and make necessary adjustments as group therapy progresses.

*Rule 1: The therapist watches for the client CRB's.* In group therapy, the therapist should attend to the many different ways that CRB1's and CRB2's can occur. Consider, for example, if our hypothetical

client suddenly started talking about her cat's behaviors. While this behavior may initially appear to be a CRB1 (talking in detail about non-important topics), it could be that this client's cat died recently and she is struggling to talk about something that matters to her. In which case, this behavior could be identified as a CRB2. Talking about things that matter is one way of making connections with others.

Rule 1 is the most important aspect of treatment. Watching the CRB1's and CRB2's will enable the therapist to identify what to block and what to elicit. This highlights the functional role of the therapist response in reinforcing or extinguishing client behavior. According to Kohlenberg and Tsai (1991), "the primary consequence of client behavior is the therapist's reaction. Without clear observation of the client's behavior by the therapist, reactions can be inconsistent or anti-therapeutic and progress will be compromised" (p. 24).

*Rule 2: The therapist evokes CRB's.* Group therapy is an environment in which CRB's are likely to occur. Groups provide benefits such as a sense of universality and cohesion and opportunities to give and to receive (Yalom, 1995). According to Rutan and Stone (2001), "The group...provides opportunities to evoke associations to current life relationships or to family of origin experiences" (p. 72). Thus, if a person has been unable to respond to opportunities to give and receive in life, to have a sense of connection and cohesion with others, and to relate skillfully with family members; group would be a perfect environment for them. Group provides an opportunity to make connections with others, and persons who have difficulty doing so generally engage in CRB1's without awareness that their behavior serves to isolate them from others. In the example given, the client begins to engage in relevant behavior targeted for treatment at the very beginning of the sessions. For instance, she begins the session by providing overly detailed information about her day, a CRB1. In this situation, the presence of group members alone elicits CRB's.

A female client who has difficulty talking to doctors may benefit from a process group if the therapist can elicit CRB's. For instance, this client might fail to make eye contact with doctors, mumble when asking them questions, or avoid attending physician appointments (CRB1's). If the client requests help with these problems, but her CRB1's do not occur when interacting with the group leader, the leader might evoke CRB1's by asking another member to play the role of the physician.

In another instance, a female client who has difficulty in intimate relationships with men but not with women may not receive the direct benefits of a women's process group that she might receive in a mixed-gender process group. For example, this client might withdraw from men who express caring (CRB1). If these behaviors occurred in a mixed-gender process group when a male client expressed caring, the identified client would have the opportunity to attend to her withdrawing behavior as it occurs in group.

*Rule 3: Reinforce CRB2's.* As stated previously, the most important rule is watching for CRB's. If the therapist fails to attend to client improvement when it occurs, the likelihood that the new behavior will be strengthened and grow closer to improvement is minimal. If the therapist is consistent about responding immediately to client improvements, however small, the relationship between the new behavior and the contingent response will be strengthened. A group leader who responds positively to a client in a warm and genuine manner when the client tries different behaviors may naturally increase the likelihood that the new behaviors will continue to occur. However, this type of response needs to be reinforcing for the client. According to Kohlenberg and Tsai (1991) "Reinforcement cannot be so defined because it is a process; an object becomes a reinforcer only in the context of the process and cannot be identified independent of it" (p. 8). Thus, thinking about the relationship between client behavior and naturally occurring consequences will help a therapist identify how client behavior can be reinforced.

From a behavioral perspective, group behavior is always reinforcing if a client returns to group. Clients who are starved for social contacts and genuine relationships will naturally be reinforced by a group that expresses a genuine interest in the client. On the other hand, a client who has a wide array of secure and

satisfying relationships may not be reinforced by an interested group, and may feel as if attending a group is exhausting due to the energy involved in keeping so many people informed of her progress.

Group leadership demands flexibility, genuineness, and the ability to shift with the group process. A therapist can make hypothesis about what is reinforcing based on the identification of CRB's (Rule 1), and can employ an array of natural responses that could be reinforcing to the client. Here are some examples of what a therapist might say to the client used in the example: "I like it when you pause and let the rest of the group catch up. It feels nice to be able to respond to what you're talking about." "There you are! I get so lost when you are talking. I feel like now we are getting to know the real you, the one behind all the words." "I want you to pay attention to the fact that others have some things to say that are positive and caring." In the third example, the therapist is increasing the client's contact with controlling contingencies (the interest of other group members).

Essentially, the leader fosters a relationship between the identified group member and the leader. The leader also fosters relationships between the identified client and other group members in order to reinforce CRB's. If the client is sorely lacking a connection with others, it is likely that the above statements will be welcomed by the client. It is more important that the therapist recognize and identify the occurrence of CRB's than for the therapist to worry about saying the right thing in response to client improvement. However, therapist statements that are intended to reinforce client behavior must actually be reinforcing to the client; thus the group leader's use of Rule 3 must be flexible and contingent on client improvement.

*Rule 4: Observe the potentially reinforcing effects of therapist behavior in relation to client CRB's.* The therapist must be aware of how his or her responses to clients impact, interfere with, or influence the therapy. If the therapist makes his or her response contingent upon client improvement, the therapist will have a powerful tool to facilitate and positively influence the outcome of treatment. If the therapist ignores how his or her behavior impacts the client or if the therapist is not aware that his or her response influences client behavior, the therapist will be without a way to facilitate behavior change.

Just as clients are reinforced by therapist behavior, therapists are also reinforced by client improvement. If a therapist is aware of times in which his or her CRB's will negatively influence treatment, the therapist can avoid taking on clients in which his or her own CRB's will inhibit positive treatment outcomes. For example, in the situation described above, the therapist may believe that interrupting the client would be rude or disrespectful. It is possible that the therapist comes from a background in which interrupting someone would seem rude or disrespectful. In this case, however, the therapist's unwillingness to make this intervention could interfere with his or her ability to intervene effectively. Other group members will likely become bored, frustrated, and agitated and may fail to return. These private experiences of other group members are naturally occurring consequences of the client behavior, and it may be necessary for the therapist to amplify such consequences with the hypothetical client in order to initiate behavior change and increase contact with controlling variables.

Rule 4 is especially significant because it requires the therapist to attend to private events and experiences. This can be a useful resource in helping the therapist identify client CRB's. In the above example, the identified client CRB1 is talking at length about details of what happened to her that day. It is likely that the therapist feels bored, frustrated, or unable to get through to her. As this experience can be lonely, the therapist may remember that the client's presenting concern was loneliness. This can enable the therapist to observe functional connections between the therapist's private experience, the client's presenting concern, and the client's CRB1.

The application of Rule 4 has received considerable attention from theorists that do not practice within a behavioral orientation. For instance, Gabbard and Wilkinson (1994), McCleary (1992), Ogden

(1979), Preston (1998), Sampson, (1991), and Solomon (1997) have written about the importance of the therapist's private experiences in understanding the therapeutic encounter. While therapist feelings and reactions to clients are often coined under terminology such as counter-transference or projective identification, these psychodynamic formulations are consistent with Rule 4 if the focus of therapist reactions is on the functional relationship between client behavior and therapist response.

*Rule 5: Give interpretations of variables that affect client behavior.* I have broken down this process into two aspects, and I have provided examples of how the therapist might use Rule 5 with the client described above. First, the therapist makes observing statements about the client's CRB1's. In this case the therapist might say: "I notice that you have been talking a lot about the details of your day, such as your laundry and your dishes." This is a result of observing Rule 1.

Second, the therapist makes statements or hypotheses about the function of the client's behavior. The therapist might state "Perhaps talking about non-important things is one way to avoid talking about the things that matter. When you don't have to risk telling people how you really feel about what's going on, you don't have to make yourself vulnerable". "Not letting others get a word in edgewise may be one way to avoid finding out if people really do care about what you have to say." "When you talk, other people might have difficulty interacting with you. It seems to me that would be very lonely. Can I offer a hypothesis? When you are around other people you tend to fear that no one in this group will really hear what you have to tell them. Is this the case?"

The group leader blocks avoidance (stops the client from providing details about her day for the entire group session) and increases the likelihood that the client will experience a felt connection with other group members. The group leader employs Rule 5 to make hypotheses about the function of the client's behavior and to elicit new responses from the client.

Rule 5 may also enable the group leader to apply Rule 3 by getting other group members involved in naturally reinforcing the client's behavior. For instance, the group leader may ask questions such as "Why do the rest of you think that she is talking so much about her laundry right now? Have other people ever rambled when they have been put on the spot? Does anyone have any ideas about why she is not talking about relationships with people?" As the group hypothesizes about the function of the client's behavior, the client will hopefully be able to make connections by relating and identifying with other group members. In addition, the leader can create a group norm in which functional statements about group members' behavior are reinforced.

It could be assumed that the client in question has a history in which her current behavior was functional in some way. Perhaps this client had many siblings who talked over her, inhibited her from speaking, or ignored her. Because her current group experience is similar to being around many siblings, the client may become anxious that she may never get an opportunity to speak. If she talks incessantly, she won't have to observe that others are not listening.

The therapist's job is to expose the client to a situation in which the immediate environment does not respond in a punitive fashion. Knowing the historical function of client behavior can help both the client and the group work with CRB's. In this situation, the therapist might say, "I don't hear anybody here in group treating you like your siblings used to treat you". The therapist elicits new responses by encouraging the client to consider positive feedback.

#### *Conceptual Summary of Identified Client*

This client's lack of attentiveness to her environment occurs in the presence of other group members. Group elicits a fear of not being heard, thus the client fails to attend to persons who could hear her. CRB1's include talking in too much detail, inattention, not hearing what others say, or talking over



other group members' responses. Essentially, the client's fear of not being heard interferes with her ability to consider an alternative possibility: People around her are interested in what she has to say. She speaks at length about unimportant things to avoid confirming her fear that no one really is listening. If she doesn't slow down and wait for group members' responses, she doesn't have to make herself vulnerable to ridicule, to interruptions, or to negative input. Ironically, her content-laden speech makes her vulnerable to the agitation and frustration of other group members. However, once the client is exposed to new responses contingent on her behavior, such as having positive input from others, change can occur.

#### Screening and Getting Started: Rule 1 in Beginning Group Process

The first part of screening a client and beginning a group is to get an agenda from each client. Knowing what the client would like from a group and why he or she is in services is the first part of identifying CRB's. The group leader can later articulate the client's presenting concern when CRB's occur in group as confirmation that both group leader and client are working towards the client's identified goals.

Below I have identified examples of reasons the client may give for wanting treatment. I then identified how CRB's show up in group. Finally, I provide examples of what the therapist might say to confirm congruency between targeted client behavior and the client's goals for treatment.

*Presenting reason for treatment:* "I can't find other partners who treat me respectfully."

*CRB1:* Client agrees with another group member who offers makes condescending statements about the client.

*Therapist statement:* "Is this one of those times in which persons are not treating you respectfully?"

*Presenting reason for treatment:* "I tend to take on everyone else's problems and worry about them"

*CRB1:* Client refrains from talking about his problems and is overly accommodating to other group members.

*Therapist statement:* "You've been pretty quiet. Are you taking on everyone else's problems right now?"

*Presenting reason for treatment:* "I can't hold down a job"

*CRB1:* Client fails to inform leader of missed sessions and comes to group irregularly.

*Therapist statement:* "Now you say you have a hard time holding down a job because your work attendance is spotty. Twice you have failed to attend group and didn't inform me of your plan to miss group. Is this the kind of thing that happens with new jobs?"

When the client first comes to therapy, the client will likely not have a very comprehensive way of articulating the problem and observing its occurrence. There is data that suggests that therapist and client disagreement over goals may play a role in therapeutic impasses (Hill, Nutt-Williams, Heaton, Rhodes, and Thompson, 1996). Clients generally feel better understood and will have respect for the leader if the leader can accurately put a finger on the problem. Assessing this as fully as possible in conducting screenings and beginning groups with new members can serve to strengthen the therapeutic alliance with the group leader and stop further misunderstandings from occurring later on. It is ideal for the client to recognize and talk about his or her presenting concerns and to express willingness to identify when the behaviors occur.

It is important for the therapist to have a working formulation of group members' CRB's. This is necessary for communication with the client, supervision, case formulation, and consultation. Additionally, being able to recognize the occurrence of CRB's for all group members will provide the therapist with a framework for effective in-group interventions. If nothing else, the therapist should obtain as much clarity as possible about the presenting concern. It is possible that the client's CRB's will not be obvious until the group begins or until the therapist has engaged in individual work with the client. For instance, it is difficult

to know why a very engaging and intelligent client would have difficulty holding down a job, but the therapist might not find out that attendance is poor until therapy has progressed. It is also possible that the client's presenting problem is too vague and offers little information about what to target. Generally, some hypothesis can be formed and discussed with the client in a screening session prior to bringing the client into the group.

While process groups may frequently evoke client CRB's, the behavioral repertoire of the group members should be considered when screening clients or formulating new groups. For instance, a group culture that encourages clients to relate directly and immediately to each other in an emotionally charged atmosphere may not be a good fit for a client who dissociates frequently. Attending to emotional overtones and commenting on them as they occur may not be within the incoming client's repertoire. The other group members may also find that working with such a group member is too tedious. For instance, the incoming member may dissociate when another member is crying, but the group may be too invested in the group conflict to attend to the new member. The new member, then, may not have the opportunity to engage in CRB2's (such as observing and describing what is going on in group) without being reinforced by the group.

Observing Rule 1 can not only help the leader identify the repertoires of incoming clients, but can additionally help the leader identify potential conflicts that may occur among group members. Being able to hypothesize as much as possible about CRB's prior to group formation should help the therapist in making screening decisions, matching clients to groups, and formatting new groups.

#### *Identifying the Occurrence of CRB's*

A questionnaire can also be provided to the client at the beginning of the group (See Appendix A). The more the client is able to accurately fill this out, the more information the leader will have in making decisions about the group screening. In addition, I have listed examples of client behaviors that may appear as CRB1's or CRB2's in order to help group leaders identify how CRB's may occur in group settings.

*Presenting concern:* "No one listens to anything I have to say."

*CRB1:* Talking in loud, overbearing tones.

*CRB2:* Speaking softly.

*Presenting concern:* "No one listens to anything I have to say."

*CRB1:* Client speaks in inaudible tones.

*CRB2:* Client speaks loudly.

*Presenting concern:* "Everyone rejects me all the time."

*CRB1:* Client insists the group leader is doing a poor job and demands the leader change the purpose or format of the group.

*CRB2:* Client helps leader to facilitate group process.

*Presenting concern:* "No one wants to hang out with me."

*CRB1:* Client is overly agreeable, compliant, and refrains from offering alternate opinions or disagreeing with the leader.

*CRB2:* Client suggests the group leader is not doing a good job.

Consider how the following behaviors may show up in group settings and may appear as CRB1's or CRB2's:

- Interrupting
- Speaking rapidly
- Sitting apart from group
- Expressing strong opinions
- Taking care of other group members

### *Introducing and Educating Clients about Goals*

This section will focus on the general goals that I have outlined for process groups. Again, informing the client of the purpose of the group will give both the leader and the group members a working framework of what will be occurring in group.

Some interpersonal process group leaders may consider clear, specified, behaviorally defined goals antithetical to process, exploration, and existential issues. However, I counter this belief by suggesting just the opposite: It is possible to have interpersonal process group goals that embrace clients' need for meaning, authenticity, and existential concerns. I further propose that failing to provide clients with group goals or failing to articulate a group purpose may increase the therapists' vulnerability to confusion and client CRB1's. I have proposed a list of group goals and I have divided them into "what" and "how" goals:

#### *What Goals:*

- Communicate effectively about how and where we get "stuck"
- Maintain a sense of connection and understanding with other group members
- Decrease behaviors that are hurtful or isolating towards self or others

#### *How Goals*

- Identify relevant behavior (where we get stuck)
- Identify when relevant behavior occurs in group
- Identify function of relevant behavior
- Identify ways relevant behaviors can be changed

When screening, it is important to educate the client about these goals. The goals are ways in which the general idea behind interpersonal process groups can be put into language that is accessible and understandable to clients. They can be introduced when the client identifies his or her reason for coming to treatment, and should be consistent with what the client would like from group therapy. If the client attempts to change the agenda of the group at a later point (CRB1 or CRB2), the group leader can negotiate the client's request while maintaining the rationale and group goals.

Because clients who are in group for interpersonal difficulties may engage in behaviors that threaten to destroy group, the energy of the group, or the potential progress of other group members, it is important not to underestimate the need to identify client goals and elicit commitment to work on them. Difficult behaviors such as personal attacks, criticism, verbal assaults, condescending or punitive language, or withdrawing can be challenging for any group. If the therapist elicits client commitment and identification of goals, there will be less opportunity for the clients to negate group process or interfere with the progress of other group members.

Used appropriately, the leader can emphasize the group goals to motivate change by bringing such goals into awareness. For example, a client who insists that the world is out to get him may experience that group members are out to get him as well. It is apparent that this worldview can be painful and diminish connections with others. The therapist might make a statement such as this: "That sounds like it is a pretty painful place to be. Thus, we've got to figure out what is going on in group that's keeping you isolated. I know that you came in here wanting to figure out how to maintain a sense of connection with other people." The therapist might then follow with a group intervention that requires the client to attend to the group members he is shutting out in making such a statement.

The how goals are consistent with Rules 1-3 and with Rule 5 of FAP. By introducing the how goals, the leader is informing the client about the ways in which the what goals will be accomplished. It may be useful to engage group members in articulating the CRB1's of other group members. While this



might happen naturally without introducing a client to the how goals, having a format initiates a forum for clients to articulate their CRB1's and the CRB1's of other group members. It may not be necessary to introduce the clients to the language of CRB's, but the group leader may use the term *relevant behavior* to encourage clients to identify target behaviors and stop them from thinking about what they do in a pejorative or shaming manner.

*Making Use of Goals for Interventions: Helping Members Identify CRB's*

Getting clear on the client's CRB's, tying the client's agenda to the group goals, and getting the client to articulate what needs to be worked on in group should be the agenda for the beginning stages of group process. Below is an example of how these things are accomplished in concert with what has been discussed so far.

The group leader might use the how goals to encourage group members to articulate the CRB1's of other group members. For example, Client A pays little attention to facial expressions and emotional responses of others. As a result, Client A tends to make blunt statements that are irrelevant to what is going on in the group (CRB1). Client B cries constantly and reports that no one seems to listen or hear what she has to say (CRB1). Requesting Client A to articulate and attend to Client B's affective expressions may serve to elicit new responses from Client A and to meet Client B's request by attending to what she is saying.

Dialogue:

Client A: I have to run some errands today (Off topic statement-CRB1).

Client B: (crying). It just seems that no one is listening to anything I have to say. (CRB1).

Therapist: (to Client A). What do you suppose is going on with her right now? (Engages Rule 3 by blocking CRB1 of Client B and eliciting new response from Client A).

Client A. I don't know.

Therapist: Do you want to find out?

Client A. Huh?

Therapist: Well, she looks pretty upset right now. Do you want to find out what she might be feeling?

Client A. Okay. (Looks at client A expectantly- CRB2).

Client B. (sniff). I'm just really sad.

Therapist. (To client B). I am noticing that someone else in group is paying attention to what you are feeling. How are you taking this?

Client B: Well, it's nice that he actually paid attention.(CRB2)

Therapist: (To Client A). Did you notice that she just gave you some positive feedback?

Client A: Yeah, okay. I guess so. (CRB2)

Therapist: (to Client A). You came in here stating that the world is generally out to get you. Here is an example of another group member who just told you it was really nice that you noticed she was crying. Because you've talked about how isolating it is to have the world out to get you, I want you to see if you can guess what she might be feeling when she is crying like this. You were just able to foster some kind of connection here in group. (Rule 3- Reinforce CRB2). What do you think?

In this dialogue, the group leader introduced the group how goals of identifying what group members do that get them stuck (CRB1). The group leader is doing this by encouraging cross communication of group members. The leader is also making verbal statements about in-session behavior that are consistent with the client's goals of decreasing isolation and identifying times in which the world is not out to get him.

*Summary*

A therapy group can become part of a client's direct and immediately experienced environment. Having a coherent conceptual framework with a basis in applied behaviorism can help group clinicians to format, develop, and lead interpersonal process groups. Hopefully this paper has provided clinicians with an understanding of how to identify and target which behaviors to attend to in group, as well as a consistent way of articulating and changing such behaviors within a group of clients.

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## Appendix A

**Screening questionnaire for group members**

What do you do that keeps you from making connections with other people? Please be as specific and clear as you can.  
How do these behaviors serve to protect you, keep you sane, or keep you safe?  
How would we observe these occurring in group?  
Is there anything the group can do to help you observe when these behaviors occur in group? Please explain.  
Are there things you do that keep you from making connections with other people that we would not be able to observe? Please identify them here.  
Please identify anything you would like from other people in group that will allow you to work on your concerns.  
Please identify what you would like from the group leader that will allow you to work on your concerns.  
How will the group or group leader know when what we ask is too much for you?  
If you were upset with another group member, what would you do?  
If you were thinking about leaving group, what would you do to let us know?