If You Build It, They Will Come:
Building a Robust Group Therapy Program

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Group therapy is the desert mirage of university and college counseling centers (UCCC's). It teases with potential relief from the continual influx of students seeking services from parched clinicians: Group therapy has been shown to be at least as effective as individual therapy (McRoberts, Burlingame, & Hoag, 1998; Toseland & Siporin, 1986) and evidence suggests that the issues for which college students often seek help (e.g., anxiety, depression, interpersonal concerns, self-esteem issues) are best addressed via group work (Parcover, Dunton, Gehlert, & Mitchell, 2006). Group therapy is also a cost-effective way of delivering services; and yet, group therapy is underutilized and group leaders struggle to fill their groups (Golden, Corazzini, & Grady, 1993). In this article, common obstacles to building a successful group therapy program will be identified and evolving strategies that have been useful in one large UCCC will be shared.

There are many obstacles to surmount when it comes to building a group therapy program. In fact, there are many challenges to overcome in just making a successful referral to group! Sometimes I feel like I have won the lottery when a student agrees to participate in group therapy **and** the group actually fits the student's schedule.

1) Students are often reluctant to engage in group therapy for a wide variety of reasons. Many cultural factors may come into play, heightening the stigma of seeking help and concerns about privacy. On small campuses, confidentially may be a particular concern.

2) The scheduling and timing of groups can be a major logistical obstacle, especially for students who work and have family or other responsibilities.

3) In addition, significant time and energy on the part of the group leaders are required for planning and implementation.

At the University of Texas at Austin, our group program has gradually expanded; we now offer approximately 30 groups per semester. In reflecting upon why our program has been successful, I identified 10 aspects of our program that have helped mitigate some of the above issues.

1. Group therapy is supported and valued by the administration and well-integrated into the service delivery system. In the past, Group Services was a separate entity from Clinical Services. "Clinical Services" was synonymous with individual therapy, which arguably sent the message that individual therapy was the "real" treatment and group therapy was the consolation prize.   In our current system, Group Services is subsumed under Clinical Services and the Program Director for Group Services reports to the Clinical Director. In our system, individual therapy often functions as an adjunct to group therapy (rather than the other way around). Students attend weekly group sessions and meet periodically with their individual therapists to discuss how to best utilize group.

2. Clinicians recognize the value of group, both to their clients and to themselves.

If therapists aren't excited about group and don't believe in it, then it is naturally going to be difficult to convince students that it is a worthwhile mode of treatment. Our clinicians love group!

3. There are incentives for clinicians to provide group therapy and successfully recruit for and implement their groups. At our center, clinicians are given time in their schedules for preparation, recruitment, and implementation. If clinicians lead a group with a minimum number of members, they can count that as part of their clinical hours and their individual hours are reduced. This enables the therapists who really enjoy groups to do more of it. By the same token, group leaders have an incentive to make sure that they recruit enough group members. If their group does not "make" then the hours revert back into individual hours (or possibly another group that is needed).

4. Co-leadership is the norm and clinicians view group as an opportunity for creativity and collaboration. Groups are generally co-led by a staff member and a trainee. Group leaders are encouraged to pursue creative ideas and develop new groups. Leading with different trainees brings new energy and ideas to the group. Group leaders maintain their enthusiasm and are motivated to continually improve their groups.

5.   All clinicians are involved in Group Services either as leaders or as referral sources. Almost every clinician leads at least one group and some lead two or more. All clinicians are motivated to refer to group because of our "incorporation system"—meaning that we don't have a waiting list or session limits—new clients are continually absorbed into the therapists' caseloads. Without group, we would not be able to manage our caseloads.

6. Group therapy is integrated into internship, practicum, and residency training programs. All trainees participate in group therapy. We recently changed our practicum program so that each practicum student co-leads one group per semester. Psychology interns lead two per semester; social work interns lead one or two, and psychiatric residents lead one.

7. Groups are marketed to students in a variety of ways. Our website contains student-friendly group descriptions, information about the benefits of group, frequently asked questions to dispel myths and overcome potential objections, and group schedule and status (open/full). When a new group is offered, it is often promoted on our home page.
A group display with handouts and fliers is set up in the waiting room. Group advertisements are sent to relevant list-serves and organizations on campus. And last, but certainly not least, groups are promoted internally via group services meetings, e-mails, and fliers.

8. Groups are tailored to students' lifestyles and needs. We try to balance the need to tailor treatment to the individual with practical considerations of the counseling center setting. The format of the group is varied and activities are used to capture students' interest and engage them more fully in the process. We take into account the diversity of the student population and try to address the needs of underserved populations. For example, we endeavor to reduce stigma by offering some groups offsite in familiar settings, addressing academic-related topics, and marketing groups as classes or discussion forums.

9. Pre-group information sessions rather than pre-group interviews are utilized to prepare and screen students for group. Group leaders hold a pre-group information session (PGI) for the potential group members. The 1.5-hour session begins with a general overview of group format, content, and guidelines. This has proven to be an efficient way of providing information about the group and also gives the group members a sense of what group therapy might look like. Because it saves time and energy, co-leaders can spend more time planning for group and building their co-leader relationship. There appears to be a link between the PGI screening process and increased attendance and compliance throughout the duration of the group. We suspect that this is because the prospective members who are not ready for group self-select out and those who are ready gain familiarity with the group process and potential members prior to the beginning of group.

10. Clinicians receive support and training regarding group therapy, including effective ways to refer to group: how to overcome client objections, how to get clients excited about group, and how to prepare clients for group. In terms of getting clients on board with group, we offer several suggestions such as the following: Mention group in the opening "spiel" of the intake and inserting relevant group references throughout the session. Show enthusiasm and be explicit about how the student's issues can be addressed in group therapy. Describe a "typical group member" and including

the student's presenting concerns in that description. Normalize hesitance and anxiety about group, using humor if possible, (e.g., "If you weren't anxious about doing the social anxiety group, then you probably wouldn't need it."). Explore the student's fears about group rather than being deterred by them. Dispel myths about group therapy and utilize the student's objections as evidence that group could be helpful to them (e.g., group is actually a great place to work on being more comfortable sharing personal information). *

In summary, although group therapy has the potential to solve some of the dilemmas facing UCCC's, it poses its own challenges. The comments shared above represent one center's experience and may not fit for others. My hope is that if UCCC's share their successes and challenges, their ideas and programs, as well as their data and curricula, we all can continue to hone our service delivery systems.

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*I would like to acknowledge Jeremy Sharp, Ph.D., who helped me develop handouts and training for referring to group.

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