Chapter 6

Necessary decisions when planning a group

The following list spells out decisions which need to be taken when planning a group. They are presented in the order in which they need to be made:

1 What population of persons shall I work with?
2 Is a group experience suitable for the population I intend to work with or should I choose some other way of helping?
3 If I decide to form a group, shall I work alone or with one or more co-therapists?
4 Which group structure is likely to benefit the persons to be brought into the group? What are the implications of structure for therapist style?
5 What steps do I need to take to increase the likelihood that the group will fit within its wider environment without damage ensuing either for the group or for parts of the environment?
6 What further practical decisions have to be made before the group can start?
7 How shall I monitor and assess the group and my own behaviour as therapist? How shall I find support and consultation for myself?
8 Who will be invited to join the group as members? How do I select members and compose a group? Do members need to be prepared for participating in the group, and if so, by what means?
9 What shall I say when the group first meets?

Some of these decisions matter a good deal, others not so much, but all have to be taken. Some decisions, once made, cannot be unmade without serious cost. For instance, once it is decided to bring a particular person into a group, one cannot decide later that this had been an error and exclude that person from the group. Rather, one can do this, but should not do it lightly because of the likely damaging consequences for the person and for the group. Other decisions are open to amendment in the light of further experience, and no bad consequences are likely to follow. For instance, a therapist may have decided on an open discussion group, only to realise when the sessions begin that the members cannot listen to each other and build on one another's contributions. It is not too late too change the structure and no harm will occur if one does so.

I have listed nine decisions, but there could have been more or there could have been fewer, depending on how they are grouped together or separated out. I make this point to avoid implying that there is something fixed and official about this list of nine. The order in which they are presented, I believe, makes sense. Some decisions need to be made early because they influence other decisions which can only be made as one gets nearer to finalising a plan.

Each of the decisions will be discussed in turn. A brief final section discusses bases for making decisions.

WHAT POPULATION OF PERSONS SHALL I WORK WITH?

The setting of one's work limits the kinds of people with whom one can work but certain choices usually remain. A psychiatric out-patient clinic attached to a hospital, for instance, is likely to include some people suffering from acute anxiety or depression though still managing their day-to-day lives, others on the verge of a severe breakdown, others in a crisis triggered by some change in life circumstances, and still others who have been discharged from an in-patient facility and are now living in the community. As another example: if a therapist is in private practice, potential patients tend to be managing day-to-day life (some of them, just barely) but may be experiencing different kinds and levels of anxiety, depression, isolation, uncertainty or dissatisfaction with their lives. As still another example, a centre for homeless men in a large city defines a population but, again, there is diversity. Some of the men may have been fixed in a homeless life style for a long time; others will only recently have emerged from a mental institution or prison; still others will have recently been wrenched or expelled from a family. Within each pool of potential clients or patients there is a degree of diversity. It is virtually always the case that the work setting limits but does not determine choice.

A therapist's level of experience and confidence may influence the choice of population with which to work. Some populations are much easier to work with than others, because members drawn from it can be expected to be well motivated, eager to take advantage of opportunities for sharing experiences and ventilating feelings, and unlikely to be disruptive and difficult to manage. If a group therapist is relatively inexperienced it makes sense to start with an 'easy' group, or arrange to work in the first instance with a more experienced colleague. I have been told many times in recent years, by members of training courses, that they have been pressed by their managers to take on groups which they do not feel equipped to work with. Managers are likely to want to provide for the full range of people served by the unit, to generate a 'fair' work-load, and so on. They may not take adequately into account practitioners' needs to avoid excessive anxiety, preserve their own sense of competence, and at the same time develop their skills. Negotiation is of course needed, with reference both to the sorts of people to be worked with, and forms of support through supervision or consultation. To support thei[redacted]int, practitioners

can emphasise longer-term benefits in the form of confident, motivated and increasingly skilled staff. Pressure from managers on staff to take on more and more difficult groups seems more prevalent now than it was fifteen or so years ago, when the first edition of this book was being written. Then, practitioners often reported that their managers and supervisors were wary of making use of groups, considering one-to-one work preferable. Those who wanted to work with groups had to make a case for doing so, and did not always succeed.

When choosing who to bring into a group, one decision is whether to draw the members of a prospective group from the same population or sub-population or from several. Often it makes sense to create a relatively homogeneous group by drawing from a single population. For instance, persons who have lost practical skills of living and are at about the same level of skill can usefully be brought together since members will be comparable with respect to current state; a preferred state can be identified which applies to all of them; and a programme can be devised which is likely to suit them all. Persons who belong to particular sub-populations within the larger 'victims of fate' or 'linked-fate' populations (categories 1 and 2 in Chapter 2) can be expected to understand what others who are in a similar situation are facing. On the other hand, bringing people together who have a particular physical handicap may be counter-productive because a group experience (especially a lengthy one) could support an identity based on the handicap. Young offenders brought together into a group may be so similar in outlook that they mutually support a world view which maintains them in their delinquent behaviours. If this is likely, special care needs to be taken to bring diversity into the group.

IS A GROUP EXPERIENCE SUITABLE FOR THE POPULATION I INTEND TO WORK WITH OR SHOULD I CHOOSE SOME OTHER WAY OF HELPING?

A group experience is just one of a number of ways of providing help. Others include one-to-one psychotherapy of various kinds; informal support provided in the course of group living; informal support through visits to patients or clients in their own homes; chemotherapy; or practical rather than psychotherapeutic help.

People are unlikely to profit from a group if they are unable to listen to and interact with others, or at the very least derive some comfort from being in physical proximity with others. These can be regarded as minimal criteria for the use of groups. By these criteria one might rule out the floridly psychotic, the most severely mentally handicapped, those so sunk in mental illness that close physical proximity with others is in itself profoundly threatening, and those so beset by internal concerns that they have virtually tuned out the outside world.

Sometimes it is appropriate to defer providing any form of help but simply to keep

in touch with an ongoing situation. Sometimes it is appropriate to concentrate on supporting and strengthening personal networks rather than working directly with patients or clients.

It should be emphasised that at this stage in planning one is thinking about the suitability of groups for whole populations or sub-populations, which means for persons who fit into some large category. It is often the case that a group experience is correctly judged to be potentially useful for a population *in general* but that nevertheless there are some people within the population for whom a group experience is contraindicated. Selection and preparation become important – points which are discussed later in this sequence (pp. 75–8).

IF I DECIDE TO FORM A GROUP, SHALL I WORK ALONE OR WITH ONE OR MORE CO-THERAPISTS?

This decision could be made later and is sometimes made earlier. I have placed it here because it is at this point that one is ready to think more specifically about the shape and character of the group. If there are to be co-therapists, there are advantages in collaborative planning from this point onwards. Both therapists can influence further decisions and the two together can test their potential compatibility and prepare themselves for working with the group.

Some group structures require more than one therapist. This will be the case, for instance, if a relatively large group of adolescents or latency-age children are to spend part of the time in sub-group activities. In other situations, working alone or with a colleague is a matter of choice and preference. Sometimes there is no choice, either because a co-therapist is not available and one therefore must work alone, or because the service-providing organisation has a policy of pairing a less experienced with a more experienced therapist for training purposes.

There are potential advantages and potential disadvantages in working together with someone else. Whether advantages outweigh disadvantages or vice versa depends very much on the persons concerned and whether or not they can find ways to work in a complementary, congenial and mutually supportive way. If all goes well between co-therapists, one of them may notice and act on some event which escapes the notice of the other. One may participate in a way which cues the other into understanding what is going on. Co-therapists can engage in post-session discussions. On the other hand it is both painful and counter-productive if co-therapists are incompatible to the point of undermining one another's efforts. It is a good idea to keep the possibility of working together open for a time before making a final decision. Potential co-therapists can share their views about how the group can and should operate. They can discuss and compare their personal styles when working with a group. If discussions reveal likely compatibility and complementarity, prospective co-therapists can move ahead with greater confidence. If, in contrast, discussions reveal unresolvable conflicts or very divergent thinking, it is not too late to decide not to work together.

I do not of course mean that in order to work well together co-therapists need to share precisely the same views or take a comparable stance towards the group. In fact, the advantage of co-therapy lies in a certain divergence with respect to skills, sensitivities and intervention styles. However, serious incompatibilities can occur. Acknowledging these and deciding not to work together may be painful, but not nearly so painful as trying to work, session after session, with a seriously incompatible co-therapist.

Roller and Nelson (1993) have written a useful article on co-therapy in which they discuss some of the benefits which may accrue to both the therapists and the group members, and some of the problems which may arise.

WHICH GROUP STRUCTURE IS LIKELY TO BENEFIT THE PERSONS TO BE BROUGHT INTO THE GROUP? WHAT ARE THE IMPLICATIONS OF STRUCTURE FOR THERAPIST STYLE?

Groups can be structured to rely on open discussion, topic-orientated discussion, activities or exercises, or some combination of these. Structure also includes the expected duration of the group in terms of number of sessions, whether it is to be time-limited or not, and the duration and frequency of sessions.

There are a large number of possibilities: for example, a time-limited group which is to meet for one-and-a-half hours per week and is to go on for, say, twenty sessions and rely on open discussion; a 'slow-open' group which relies on open discussion and is expected to go on indefinitely, with most patients remaining for very long periods; a short-term time-limited group which is to meet once a week for twelve weeks and discuss a different topic each time, set by the therapist; a short-term time-limited group which is to meet for eight sessions and make use of open discussion; a group which is to meet once a month indefinitely, with each session devoted to a particular topic; a group which is to meet daily for five days, two hours at a time, with each session pre-planned to include periods of exercises or activities followed by periods of discussion; an activity-based group which is to meet once a week for two-and-a-half hours with no planned termination date; and so on.

It should be mentioned parenthetically that open-discussion groups are sometimes referred to as 'unstructured'. This is not accurate, for open discussion is as much a structure as any other, though the structure is not as 'heavy' as in, for instance, a group in which the therapist expects to lead people though pre-planned activities.

With reference to time span, I have the impression (no proof) that many therapists assume that very long-term groups are 'deeper' and therefore better than short-term groups, which are regarded as more 'superficial'. Such an assumption misses the point that the duration of the group, along with other elements of structure, ought to match the situation and needs of the prospective members. Some people (especially those drawn from a population of people who share some preoccupying

concern) are essentially psychologically healthy. They are not in need of fundamental personality change, are able to move quickly into discussing significant personal material, and do not need a very lengthy therapeutic experience. People who persistently engage in self-defeating behaviours, become involved in destructive or unfulfilling relationships and/or have adopted unsatisfying life styles are likely to need a longer-term therapeutic experience. Very damaged people also may need a longer term of experience which offers ongoing support, or they may profit from a number of short-term group experiences dispersed over time.

In making decisions concerning a group's structure, one is aiming for internal viability: a group which will function reasonably well, most of the time, as a therapeutic environment suited to and usable by its members. Arriving at a suitable structure is an act of the informed imagination. It requires the forecasting of the likely consequences of one set of decisions rather than another, on the basis of one's understanding of a population or sub-population; awareness of the range of groups which *can* be designed; and an appreciation of the demands which different structures make on group members. Sometimes a choice needs to be made between alternative structures which are judged to be equally suitable. A structure is not desirable or undesirable on its own, but only in the light of the needs and capabilities of the population it is intended to serve.

The structure decided upon will have implications for therapist style. Open discussion groups, for instance, require the therapist to be inactive enough to allow themes to arise in the group, yet ready to be active when members need support or encouragement to explore further, or when members run out of their own resources. Activity-centred groups require a more active style in which the therapist introduces activities and guides members through them. A time-limited group requires the therapist to remind members of time constraints at the beginning of the group and again towards the end, and to support as full use as possible of the termination phase of the group. Co-therapists who discuss such matters beforehand are more likely to work effectively together.

WHAT STEPS DO I NEED TO TAKE TO INCREASE THE LIKELIHOOD THAT THE GROUP WILL FIT WITHIN ITS WIDER ENVIRONMENT WITHOUT DAMAGE ENSUING EITHER FOR THE GROUP OR FOR PARTS OF THE ENVIRONMENT?

Internal viability is of course essential but a group also has to survive in its environment. Few if any groups are isolated and insulated from a wider environment – usually a service-providing organisation of some kind and a network of outside organisations and/or individuals. Within a service-providing unit or organisation, diverse activities for patients (or clients or attenders) may be combined into a programme including, for instance, one-to-one psychotherapy, community or ward meetings, a programme of activities and outings and so on and one or more

therapeutic groups. A therapeutic group for patients or clients or residents may exist side by side with groups for relatives. A network of outside individuals and organisations often bears on work with a group: for instance, schools, the police, probation officers, and so on. Even therapists in private practice – a work setting which may appear to be independent – are likely to rely upon a network of referrers.

A group is not always a good fit with the larger organisation of which it is a part. Especially if conducting groups is a new venture within an organisation, the very fact that there *is* a group may upset established ways of thinking about accountability, of allocating work, of using space. There may be conflicts or potential conflicts among staff over jurisdiction and responsibility. One part of the programme could undermine the effectiveness of another, or members of staff might fear that this could happen. A patient or client who is in both individual and group therapy could behave in ways which set the therapists against one another. Managers may require forms of record-keeping which the group therapist considers likely to interfere with maintaining confidentiality within the group. And so on.

At this stage in planning, the prospective group therapist(s), other staff directly involved with people likely to become group members, and managers need to communicate with one another over planning decisions, so that the impact of the group on the organisation, and vice versa, can be anticipated in so far as this is possible before the group actually begins. Decisions need to be made about what kinds of ongoing communication, with whom, need to be provided for. The aim of course is to achieve complementarity, and to avoid working at cross-purposes or allowing one part of a programme to sabotage another part of it.

Inter-organisational and network dynamics can easily involve conflicts of interest. This is understandable when one considers that organisational or professional cultures differ one from the other with respect to goals, procedures, and world view, including assumptions about what is good for people and how staff should operate. It is not unusual for a school, for example, or the police to pursue policies or take actions which work against what the staff of a residential facility consider to be the best interests of those in their care. Some inter-organisational problems are ongoing. They are never really solved, but need constant attention to keep them under a degree of control.

WHAT FURTHER PRACTICAL DECISIONS HAVE TO BE MADE BEFORE THE GROUP CAN START?

Further practical decisions have to do with the number of persons to be included in the group, venue, the arrangement of the room, and the records which are to be kept.

The size of the group will influence the experiences of its members. A large group allows some members to locate themselves at the periphery of the group (which may be suitable for some populations and not others). A very small group loses opportunities for exchange and interpersonal comparison. There are differences of

opinion in the literature as to how big is too big, and how small is too small, but usually a membership of six to nine or so is regarded as about right.

Sometimes there is choice as to venue and sometimes there is not. A group needs to meet *somewhere*, but less-than-ideal meeting places can be tolerated and do not necessarily work against the viability of the group. This was brought home to me on an occasion when the only place available to me to conduct a group composed of psychiatric inpatients was an alcove at one side of a large ward. Everything that went on in the group was open to view, and if non-members were near enough they could hear the conversation. This struck me as a serious disadvantage, for how could privacy and confidentiality be maintained? Yet things turned out well and the setting proved to be an advantage. A few of those who had declined to join the group stationed themselves just outside the alcove, where they could hear all that occurred. One person changed her position each time, sometimes approaching, sometimes moving away. I judged that these 'non-members' might be achieving some benefit, although there was no evidence one way or the other. It seemed reasonable to suppose that they were regulating their degree of exposure to the group, possibly gaining some benefits through watching and listening, while avoiding direct participation.

The arrangement within the meeting room – for instance, whether there is to be a table or an open circle of chairs – matters and can be influenced by the therapist. Some people feel safer and less exposed if they are sitting at a table. Others can tolerate an open circle. All the chairs should be the same.

A decision will also have to be made about whether to keep written records and if so, what kinds. Some forms of record-keeping may be required by managers or heads of units. In addition or instead, therapists may decide to keep certain forms of records to support their own learning both while the group is going on and afterwards (see the next sub-section, below, and Chapter 18, where this point is developed in further detail).

HOW SHALL I MONITOR AND ASSESS THE GROUP, AND MY OWN BEHAVIOUR AS THERAPIST? HOW SHALL I FIND SUPPORT AND CONSULTATION FOR MYSELF?

Structures and procedures for monitoring and assessing a group need to be decided upon before a group actually begins. It is no use deciding by the sixth or eighth session that it would have been interesting and useful to have notes of each session, or that co-therapists could profitably have engaged in post-session discussions, or that it would have been valuable to have assessed, at the start of the group, each member's current state in order to help in making judgements later on about gains. Monitoring and assessing will not happen unless planned from the start.

I take it for granted that some form of monitoring and assessing should go on as the group proceeds, and also that much can be gained by reviewing a group after it has ended. I will not go into further detail here, because structures and procedures

and how they may actually be used is discussed in detail in Chapter 18, which is about learning from one's own practice experience.

WHO WILL BE INVITED TO JOIN THE GROUP AS MEMBERS? HOW DO I SELECT MEMBERS, AND COMPOSE A GROUP? DO MEMBERS NEED TO BE PREPARED FOR PARTICIPATING IN A GROUP, AND IF SO, BY WHAT MEANS?

Selection and composition are important tasks which influence how well the group is likely to operate once it gets going. Preparation is useful for some kinds of groups and populations; not so crucial for others.

With regard to selection, it seems best not to bring into a group anyone in an acute state of crisis or anyone who displays profound dread of entering a group and is unable to articulate anything further about the nature of the dread, or reasons for it. Dread is not the same as fear, and still less is it the same as having reservations about being in a group. Many people have reservations about entering a group but are nevertheless prepared to join one, especially if their reservations can be aired in a preliminary interview.

With regard to composition, groups seem to work best if they are *homogeneous* with regard to level of vulnerability, and *heterogeneous* with regard to preferred defences. If a group contains one or a few people who are much more personally vulnerable than the others, the majority will move relatively quickly into areas which the more vulnerable ones find intolerably threatening. The risk is that some individuals will become over-faced and withdraw literally or psychologically from the group.

Heterogeneity with respect to preferred defence is desirable because it lessens the risk that individual preferences will be mutually supported and reinforced through the group interaction, thus becoming established as collusive defences (in group focal conflict terms, as restrictive solutions). One need only imagine a group made up of intellectualisers or of deniers to see the point of this. If *everyone* intellectualises or denies there will be no one within the group membership to challenge the defence or provide any contrast with it. There is a risk of the group getting stuck in some unprofitable or constricted way of interacting.

In general, it is best to avoid including anyone who stands out in comparison with the others by virtue of age, sex, race, level of education and so on. This point of view is supported by theory. If there is just *one* person who is much older or is noticeably better educated than the others, it becomes easy for the members to locate such a person within some restrictive solution (such as making use of the person as a substitute therapist). This holds the person in a position or role within the group which tends to insulate him or her from potentially beneficial experiences associated with sharing and comparing. There is also a risk of one member becoming stereotyped. If there is, say, only *one* man in a group otherwise composed of women, he

may become the repository of attitudes towards men in general. He may be deprived of opportunities to be seen for what he is. Instead, he is seen as what others assume he must be. The same point can be made, of course, if there is just one woman in an otherwise all male group, or one black in a group otherwise composed of whites, or vice versa. This principle of composition can be understood in group focal conflict terms but one can arrive at the same point of view by different routes. This same principle is referred to by MacKenzie (1990) as the 'Noah's Ark' principle and by Pollack and Slan (1995) as the 'sore thumb' principle.

Selecting members with an eye to the composition of a group is one of the more important planning decisions, judged by potential consequences. The question remains as to the means by which a suitable composition can be achieved. Since composing a group is a somewhat inexact art, it would be better to say that the question is how to avoid the most dysfunctional compositions. There are two main courses of action open to a therapist. The first is to accept members on a first come, first served basis. The second is to carry out selection interviews. Either course of action can be justified, depending on circumstances.

Consider the first alternative: sometimes selection is not possible, for instance if one must work with, or at least extend invitations to, all the residents of a hostel or other residential facility. Sometimes selection is possible but unlikely to have a better result than bringing people into a group on a first-come, first-served basis. For instance, membership might be formed by open invitation to a potential population of participants – for example, to all parents of physically handicapped children attending an out-patient clinic. The group will be composed of individuals who opt in to the activity. This route can be chosen if there is no reason to believe that the homogeneity–heterogeneity principles named above will be violated.

Sometimes one wishes to take a more active part in decisions about selection and composition by conducting selection interviews. This will be the case if it cannot reasonably be assumed that virtually any member of a population will be a suitable candidate for a group experience, or if it is judged that there is a risk of ending up with an unbalanced composition.

A selection interview serves multiple purposes: it can provide information which helps one to decide whether or not to invite a person into a group; it can constitute preparation for prospective group members; and it allows a therapist to build up a group composition person by person, and so have some control over the balance in the membership.

If possible, it is best to begin a selection interview by getting to know the person without immediately bringing up the possibility of a group. As the discussion proceeds, one might judge that the person should not be brought into a group, for instance if he or she appears to be seriously threatened by the prospect of being in a group, or in a state of crisis. If so, one looks for alternative forms of help. The person need not feel that s/he failed some sort of admission test, because a group has not been mentioned. Taking this approach in a selection interview obviously depends on there being alternative forms of help available in the setting, or alternative sources of help to which an individual can easily be referred.

If, as the interview proceeds, one judges the person to be a potentially suitable candidate, one mentions the possibility of a group experience, and the person will respond with enthusiasm (not so frequent), with some reservations (quite frequent), or with dread (again, not so frequent).

Suppose that a person expresses fears and reservations. These can then be explored. Amongst the reservations which people express are fearing that others will look down on them or criticise or ridicule them; or that they will experience shame; or that there are personal matters which they could never bring up; or that they will say things about themselves which will upset them or which they will regret having said; or that everyone will know more than they do or be better off than they are; or that topics will come up in the group which will be upsetting. The therapist will of course acknowledge and discuss whichever worries surface. If fears can be named, and if the interviewer respects them and seeks to explore and understand them, this in itself is often enough to tip the balance and bring the person to the point of feeling ready to try a group. Some people will say that they prefer individual psychotherapy. When asked why, they may refer to some of these same fears and reservations, and/or they may say that in a group they will not have the exclusive attention of a therapist (which is of course true). The assumption that one needs the specific and exclusive attention of one professionally trained helper in order to achieve personal gains is widespread in the broader culture and it is no surprise that many people share it. If anyone makes this point one might say: 'Of course that is true, because the therapist has to listen to and try to understand everyone, but on the other hand the group creates opportunities to discuss common concerns with others in a similar situation, and to share and compare one's own situation and feelings with those of others.' This may or may not lead a person towards being ready to join a group. Sometimes one can alleviate fears by assuring people that they can decide for themselves what to say and what not to say.

Some people express dread when the possibility of a group is mentioned. Dread, by dictionary definition, is 'to look forward to with terror' (*Shorter Oxford English Dictionary*). Dread – really profound and unarticulated fear – is different from nameable fears and reservations. People who dread groups are often quite unable to say just what it is about a group that is so dreadful. They are alarmed at the prospect of being in a group in some gross, profound, and often inchoate way. When invited to give examples of the bad things that could happen, they are unable to do so. They are utterly convinced that they will be unable to cope. They cannot say more about it, and cannot name or examine their fears. Such people are most likely sensing something in themselves which makes being in a group somehow terribly dangerous. One does not encounter dread so very often but when one does it seems to me best to find some alternative form of help. The person concerned is sensing a personal vulnerability which may well make being in a group a damaging rather than a helpful experience.

After an interview has gone on for some time it is usually possible to form a view as to whether or not the person is a suitable candidate for the group one is forming. If one judges that the person could manage and profit from the group, and will fit

into the composition, one can ask: 'What do you think? Join a group?' If the person says: 'Yes, o.k.' it is likely to mean that he or she feels that certain fears, though quite possibly still present, will prove to be manageable. If one judges that the person is likely to be overwhelmed by group events, or will not fit the emerging composition, one can quietly drop the matter and offer some alternative form of help.

A selection interview of the kind just described can constitute useful preparation for a group experience. The individual rehearses, for him- or herself, what a group is probably going to be like, what could or could not easily be said and shared in it, and what fears and anxieties are likely to be experienced. Some therapists recommend much more elaborate and extended forms of preparation. MacKenzie (1990) suggests several individual preparatory interviews, and/or one or two pre-therapy group discussions. He points out that individual sessions help a person to find a focus for his or her participation in the group, especially useful for short-term groups. Preparation which consists of pre-group meetings may include structured exercises, or discussion based on a rather lengthy information handout which MacKenzie gives to prospective group members beforehand. This includes sections titled 'Do groups really help people?'; 'How group therapy works'; 'Common myths about group therapy'; 'How to get the most out of group therapy'; 'Common stumbling blocks'; and 'Group rules' (see MacKenzie 1990: 107–14). When the group meets for its preparatory work, MacKenzie takes those present through the handout, paragraph by paragraph. Budman does something similar though not so elaborate. He and his colleagues prepare people for membership through individual interviews lasting 30–60 minutes, plus participation in a one-and-a-half hour pre-group workshop (Budman *et al.* 1996). (See the first example in Chapter 7.)

Decisions about what whether or not to offer preparation, and the sort of preparation to offer, are based on one's understanding of the population to be worked with, and also on the expected duration of the group. Those who, like MacKenzie, expect to work in relatively short-term time-limited groups often emphasise the usefulness of preparatory work which makes a 'jump-start' more likely.

One more decision needs to be made before the group actually starts.

WHAT SHALL I SAY WHEN THE GROUP FIRST MEETS?

There are many ways to open a group. Amongst these are referring to what the members have in common, referring to opportunities to share and compare experiences, describing the procedures to be followed (for example, open discussion, exercises, and so on), reminding members of meeting times, introducing the members, not introducing the members, getting members started with an exercise or activity if one is to be used, or saying nothing.

In general, whatever one does to open a group should support the structure one has in mind and make it easier for people to begin to participate. The structure is more likely to work as intended if it is described at the beginning even if members already know about it through an individual interview or other preparatory work. Thus one might refer to meeting times and places, the duration of sessions, the duration of the group, and expected procedures.

Is it appropriate to say nothing at all? This is recommended by some therapists who work with long-term ongoing groups in which 'uncovering' is to be emphasised. Saying nothing places responsibility for getting started squarely on the members. It also tends to stir up anxiety so, if considering getting started by saying nothing, one has be fairly sure that group members can tolerate anxiety and not respond by fleeing from the group. On the grounds that, in many groups, saying nothing generates unmanageable levels of anxiety and does not help a group to get started, I favour some sort of opening comment. Most people tend to feel reassured if they at least hear the therapist's voice.

Some group therapists or workers lay down ground rules about, for instance, attending regularly, coming to sessions on time, maintaining confidentiality, or avoiding contact with one another outside the group. Some make use of written contracts. Reminding members of the structure is in itself a mild form of pressure (for example,'We will meet on Monday and Thursday nights, beginning at 7.30 pm, for one-and-a-half hours'). Some therapists introduce not only rules, but sanctions if rules are broken. For instance, members may be told at the start that overt violence will be followed by expulsion from the group.

Decisions about whether or not to state guidelines, make rules, and introduce and utilise sanctions have to be made with reference to each group, taking into account its structure and the population being served. Stating rules and guidelines does not guarantee conformity to them. Group therapists cannot control punctuality and so on. Rather than stating rules prescriptively, a therapist may decide to say that 'a group usually works best if . . .'. Or a therapist may decide to say nothing at all about such matters on the grounds that, if members are concerned about, for instance, confidentiality, they will bring up the matter themselves. If attendance, tardiness, or outside contacts occur and interfere with the effectiveness of the group, that may be the time to pay attention to them.

Very lengthy opening statements are to be avoided on grounds that they unnecessarily postpone the start of the group.

BASES FOR MAKING DECISIONS

Decisions should be made in the light of anticipated consequences. When planning a therapeutic group, the best decisions are those which tilt the probabilities towards benefiting the individuals who are to become members. One constantly asks oneself: When making this particular decision, what alternatives are possible and what are the most likely consequences of each?

Decisions which need to be made when planning a group are interrelated. If one decides to conduct a short-term group, one will want members to move into productive work as quickly as possible. Consequently one will need to decide whether members' own strong motivations will move them into useful exchanges quickly, or whether preparation is needed to make a 'jump-start' more likely. If the population one intends to work with is inherently homogeneous with respect to traits likely to influence the work of therapy, one will need to make a specific effort to balance the composition. And so on.

A therapist's freedom of choice when planning a group may be restricted by circumstances outside his or her own control, located in policies and practices in the work setting. Some populations will be available, others will not. A therapist may be obliged by organisational policy to work with a co-therapist. Policy may favour short-term groups. And so on. Despite limitations on choice, and despite not being able always to predict the consequences of one decision over another, careful attention to planning has pay-offs for the group. Decisions made during planning cannot guarantee a viable and benefit-promoting group, but they can influence probabilities in a positive direction.