To the Graduate Council:

I am submitting herewith a thesis written by Lynn Beaman English entitled "The Working Stages of Group Therapy as a Predictor of Aftercare Attendance." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Educational Psychology.

William A. Poppen

Dr. William A. Poppen,
Major Professor

We have read this thesis
and recommend its acceptance:

Accepted for the Council:

Associate Vice Chancellor and
Dean of The Graduate School

THE WORKING STAGES OF GROUP THERAPY AS A PREDICTOR OF AFTERCARE ATTENDANCE

A THESIS
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MASTER OF SCIENCE
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Lynn Beaman English
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Thanks to all of you for your love and support. You have helped to broaden my world and I am forever grateful.

DEDICATION

This study is dedicated in memory of Sharon Faye Adams Smith, (April 1, 1946 - November 23, 1993). She helped to bring groups to life for me; a gift that will always be with me. Her physical presence is deeply missed.

ABSTRACT

The purpose of this study was to determine if greater frequency in a working stage of interactive group therapy for chemically dependent clients is a manipulable factor predictive of at least 6 months of aftercare attendance.

Data was collected on 103 consecutive admissions to the Alcohol and Drug Recovery Center outpatient office.

Following each group therapy session perceived group stage was rated and recorded by the staff psychologist for each client based on their behavior in that group session. Reliability of the rating was assessed by comparing the psychologist's rating with the rating of this writer and one other staff counselor who each rated 30 separate groups independently.

Thirty-seven clients successfully completed primary treatment and were referred for one year of aftercare. Attendance at aftercare was recorded in each client's medical record.

The 37 clients were divided into two groups based on their participation in less than 10 working groups or equal to or greater than 10 groups in a working stage. The number 10 was chosen after determining the median and the mean number of working groups participated in by those 37 clients. A chi square test revealed no significant difference in aftercare attendance between the two groups.

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CHAPTER I

THE NATURE AND PURPOSE OF THE INVESTIGATION

Introduction

Group therapy has become the treatment of choice for those treating the chemically dependent population (Flores, 1988 & Yalom, 1991). It is considered a significant component of a psychoeducational approach for treatment of the chemically dependent client. The approach generally includes an educational component and recommendation that clients concurrently attend a twelve step self-help group such as Alcoholics Anonymous. Group therapy is utilized to provide structure for the unlearning of old, self-defeating behaviors and the learning of more adaptive behaviors (Flores, 1988).

Group therapy is comprised of a number of stages apparent to the trained therapist. Each stage contributes uniquely to what and how members learn in group therapy (Kivlighan, & Goldfine, 1991). The traditional interactive approach to group therapy is modified to address issues specific to addicted populations (Flores, 1988; Yalom, 1985). Group therapy is used in both primary treatment and aftercare with the focus shifting somewhat according to the perceived stage of the group.

Aftercare is provided to individuals who complete primary treatment and are considered stabilized in their

sobriety. It has been described as an important component of a holistic treatment package that aids in the maintenance of sobriety and plays an important role of breaking into the relapse cycle (Mumme', 1991, Vannicelli, 1988 and Ito and Donovan, 1986).

Statement of the Problem

A review of the literature by Ito and Donovan (1986, p. 453) suggests that there is a need to determine manipulable factors in primary treatment of chemical dependence that predict aftercare attendance. However, no research has been reported examining frequency of participating in various group stages as predictors of aftercare attendance. Therefore this study is directed toward filling that void in the literature.

Hypothesis

Those clients in primary treatment of chemical dependence who reach a working stage in group therapy with greater frequency than those clients who do not while in primary treatment are more likely to complete six months of aftercare.

Definition of Terms

Clients. Those persons who seek professional treatment to address their chemical dependence. Clients are

voluntary. They are given a specific psychiatric diagnosis based on the DSM III-R upon admission.

Primary Treatment. The core of psychological, therapeutic, and educational services delivered by professionals in the treatment of chemical dependence. Completion of primary treatment typically involves participation in between 20 and 30 group therapy sessions, weekly educational groups and other therapeutic activities. These services are provided in order to educate the client on their addiction, aid in the recognition and change of self-defeating behaviors that might interfere with the recovery process and stabilization in sobriety. A multidisciplinary treatment team determines length of stay in primary treatment based upon completion of treatment goals and objectives.

Working Stage. A stage of group therapy that is characterized by group cohesion and a focus on the here and now. Group members, rather than co-facilitators, assume greater responsibility for addressing interpersonal style and conflict or self-defeating behaviors and attitudes that manifest themselves in the group therapy session. Group facilitators guide the group through less mature group stages in an attempt to reach this stage which is believed to be most beneficial to clients.

Aftercare. A one and one-half hour group therapy session provided one time weekly for those clients who

complete primary treatment. The sessions are free of charge and it is recommended that clients remain in the group for one year following discharge from primary treatment. The group therapy sessions were open and typically included eight to twelve members. Ito and Donovan, (1986) and Vannicelli, (1988) describe the purpose of aftercare as a significant component of the treatment process. It is designed to aid in the maintenance of therapeutic gains made while in primary treatment and the early detection and intervention into the relapse process.

Open Group. Group therapy groups which have continuous membership changes. Clients are admitted to a group that is already formed when they enter primary treatment and others leave the group when they have completed primary treatment.

Closed Group. Group therapy groups that are stable with regard to membership.

Structure of Group. Group therapy sessions, which are open, include up to 12 clients and are co-facilitated by a staff psychologist and a staff counselor. One staff member tracks verbal content and the other tracks the process, or interactional behavior of group members.

Members and co-facilitators form a circle with their chairs prior to the start and the door is closed. Group therapy sessions are begun with the clients reciting the purpose of the group and then the rules of the group. When a new client is present brief introductions are made and the

purpose and rules of the group are explained. Each group member is asked if he or she would like group time today. The time is divided equally among those who claim group time and is tracked by the facilitator who is following client content for that session.

After the clients have used their group time the facilitator responsible for observing the process of the group comments on behaviors observed throughout the group. Feedback is given to individuals as well as the group as a whole regarding behavior observed.

Following the processing of the group session group members stand in a circle with their arms around one another and recite the Serenity Prayer. The group disperses.

Group Process Recording Sheet. The form used to record data on each client regarding perceived group stage immediately following each group session. Data was collected and recorded by the staff psychologist for each of the 103 clients involved in this study. A copy of the form can be found as Appendix A.

Inter-Rater Agreement Recording Form. The form used to record group stage data on 60 group therapy sessions in order to assess inter-rater reliability between the staff psychologist and two staff counselors. The form can be found as Appendix B.

Significance of The Study

This study is designed to examine the data that could be useful in predicting aftercare attendance following primary treatment for chemical dependence. If the results indicate that those clients who reached a working stage of group therapy more frequently while in primary treatment were more likely to remain in aftercare for six months than those who did not, then a manipulable factor has been uncovered which helps to predict aftercare attendance following primary treatment for chemical dependence.

Assumptions and Limitations

One assumption made in this study is that the group therapy stages were accurately detected and reported by each of the co-facilitators. Another assumption is that the co-facilitators were able to aid in the movement of the group to a working stage so as to make the group stages manipulable factors. A final assumption is that all clients have equal opportunity to move into and participate in groups that reach a working stage.

A major limitation of the study is that there were only two observers of the group stages who were both involved in the co-facilitation of the group at the time it was being observed. Another limitation is that the study was conducted on an outpatient basis and may not generalize to other populations.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

This chapter contains reviews of the literature related to treatment of the chemically dependent client using an interactional group therapy approach that has been modified for that population. A significant portion of the treatment process involves regular participation in these groups. A primary goal of the group therapy process is reaching what is known as a working stage. This is true for groups in both primary treatment and in aftercare. It is typically recommended that clients participate in aftercare group therapy sessions one time weekly for one year following primary treatment. Ito and Donovan, (1986) suggest that manipulable factors need to be uncovered that help to predict aftercare attendance. The review will include: (1) a brief discussion of group therapy stages, (2) modification of the group therapy process for treatment of the chemically dependent population, and (3) the significance of aftercare attendance.

Stages of Group Therapy

Professionals trained in group therapy acknowledge a developmental sequence that operates throughout the life of the group. These developmental stages provide clues or

constructs that enable the therapist to determine the appropriate interventions or amount of structuring that is optimal in each stage of development (Yalom, 1985; Corey & Corey, 1987). The stages of group overlap considerably and it is typical for a group that has reached a more mature stage to regress temporarily (Corey & Corey, 1987). Tasks addressed at an early stage are frequently addressed at a later stage with a different perspective and in greater depth (Yalom, 1985). The process encompasses the evolution of group norms, roles, cohesion and interactional patterns (Rose, 1989). Further, the group is frequently faced with membership problems such as turnover, absence, tardiness and subgrouping. Other issues which are inevitable in the process include conflict and termination (Yalom, 1985). Proper management of these and other issues are essential to the functioning of the group. Therapists, with an understanding of the group's stage, are able to diagnose the group with reference to it's goal and the pacing of it's work (Zimpfer, 1986).

The forming group encompasses two major tasks. Group members must determine a method of achieving their primary task- the purpose for which they joined the group, and create a niche for themselves among their peers (Yalom, 1985). Anxiety is high as the group begins to address these primary tasks (Yalom, 1985; Corey & Corey, 1987). A significant amount of energy is directed toward the search

for approval, acceptance, respect or domination throughout this stage (Yalom, 1985). Content and communicational style are relatively stereotypical and problems are addressed rationally. Considerable advice giving is indicative of a forming group as is storytelling and the search for similarities among group members (Yalom, 1985). Members begin developing a sense of cohesiveness as they focus on the one thing they know that they have in common-their addiction. The topic is warranted in that it is relevant to one of the stated tasks of the group (Vannicelli, 1988). The focus on the addiction also helps to bring into play some of the therapeutic factors. The instillation of hope and universality are two such factors that help to form a group whose chief concerns are of survival, establishing boundaries and maintaining membership (Yalom, 1985 p. 107). Therapists provide structure during this stage, that is aimed at helping members express their fears, expectations, and personal goals (Corey & Corey, 1987). Along with structure, therapists are looked to for answers, approval and acceptance (Yalom, 1985). A level of trust begins to develop as the therapist acts as a model for desired behavior and provides appropriate structure (Corey and Corey, 1987).

Before groups move into what is considered a working stage of group therapy they move into a storming group stage that is characterized by conflict, dominance, and rebellion

(Yalom, 1985; Corey & Corey, 1987). Group members rebel against the leader, the structure and each other. The ability to move forward in the process is dependent upon facing these various forms of resistance. When conflict in a group is encouraged to be expressed openly and is addressed appropriately the group becomes more cohesive and is ready to move to the next stage.

The third stage of a group, generally known as the working stage (Corey & Corey, 1987; Yalom, 1985) is characterized by group cohesion that has developed as a part of progressing successfully through the first two stages. Group cohesion continues to develop as group members begin to reveal themselves more openly to their peers. Early on in the working stage members develop a sense of "us against the rest of the world." Later, as group members begin to address hostility in the group from a different more mature perspective, true teamwork begins. Members work to keep the group from regressing to an earlier stage (Yalom, 1985). Rather than addressing those issues outside the group the focus is on the here and now. Group members display more honestly their interpersonal style and begin to see their effect on one another (Zimpfer, 1986). Feedback is given more freely and is generally accepted without defensiveness (Corey & Corey, 1987). It is at this time when members truly begin to experiment with new behaviors (Yalom, 1985). During this stage of development leadership functions are

shared by group members as they begin to take more responsibility for the group. The degree of structuring is much lower than in the earlier stages (Corey & Corey, 1987). Once the group has reached this stage the therapeutic factors, described by Yalom (1985), are most pronounced.

Another stage of development inevitable in any group involves the issue of termination. It is characteristic for group members to pull back from the group and participate in less intense ways (Yalom, 1985; Corey & Corey, 1987). The member that is terminating will oftentimes exhibit old symptomology. They may attempt to create bridges to the group as a means of staying connected rather than terminate. At the same time, remaining group members may apply pressure for the terminating member to remain in the group. During this stage it is common for group members to examine their own progress. The issue of loss is addressed on more than one level. It is a good time to encourage group members to deal with other losses such as the rush of time, death, and aging. With the loss of a group member it is common for roles to shift as one group member, typically a senior member, attempts to fill the void left by the terminating member. The group reforms and continues to work to maintain the level of functioning reached prior to the termination (Yalom, 1985).

Group Psychotherapy With Addicted Populations

Experts (Yalom, 1985; Flores, 1988; Matano & Yalom, 1991) agree that it is essential to adapt the principles of group psychotherapy to work effectively with addictive populations. The primary concern in treatment of this population is the maintenance of sobriety. The belief is that without sobriety no real therapeutic work can take place.

Yalom, (1985) described those clients addicted to alcohol or drugs as "poor candidates" for a heterogeneous group. He noted that the difficulty lies in those clients being unable to participate in the primary task of the group. Group therapy is not contraindicated for this population. Instead, he recommends a specialized form of group with a more homogeneous population.

Flores (1988) described an adaptation based on the disease model of chemical dependence. In this model, addiction is viewed as a chronic illness that can not be cured but that can be arrested. Accepting addiction as a disease requires that one view this condition as a physiological illness with recognizable signs and symptoms. The disease is primary in nature not secondary to an underlying mental or emotional disorder. Along with the recognition of the illness one must also accept the likelihood of relapse. Group psychotherapy from this perspective is aimed at identifying the defenses and

characterological deficits that prevent compliance to abstinence and recovery rather than uncovering psychological pathology. Only when the addict becomes stable in his or her sobriety can they begin to address the uncomfortable feelings triggered by interpersonal conflict. It is suggested that group psychotherapy be used to enhance the principles of Alcoholics Anonymous since chemical dependence is viewed as a disease that requires life long abstinence and ongoing support.

Matano and Yalom (1991) describe five principles that provide guidelines for the clinician using interactive group therapy with chemically dependent clients. The first consideration is the priority of recovery. The interpersonal approach early on should be gentle and supportive to the new group member. If the client begins to demonstrate behaviors that are a threat to the recovery process, the focus should shift from the interpersonal to refortifying the client's basic behavioral and social supports. The second principle is the identification of the client as an alcoholic/addict. This is important for the emphasis on sameness which contributes to the increase of cohesion, trust, safety, and the belief that others can help. Another principle involves careful modulation of anxiety levels. It is extremely important that anxiety levels do not overwhelm the clients' coping resources. It is not the goal of the therapist to eradicate the anxiety

but to manage it carefully so as not to set the client up for relapse. The fourth consideration is the delineation of responsibility for the disease and arresting it's symptoms. In this approach clients are not held responsible for the addiction itself. Further, they are not to be held responsible for their loss of control or their beliefs and values about drinking which have become deeply ingrained. However, clients should be held responsible for taking the first drink or drug. They are held responsible for actively working the suggested twelve steps of Alcoholics Anonymous and/or Narcotics Anonymous. Lastly, the clients are to be held responsible for how they choose to relate to others in the here and now. Finally the group process must be modified to incorporate the language and belief systems of the twelve step programs of A.A. and N.A.. Two reasons were given for this last principle: (1) to draw on the knowledge of A.A. and incorporate that knowledge into the therapy process and (2) to spot and prevent the misuse of A.A. concepts-that is, their distortion and utilization in therapy resistance (Vannicelli, 1988). It is the belief of these authors that A.A. and psychotherapy are not competing forces but are mutually augmentative.

Other common clinical themes in working with chemically dependent populations were noted by Matano and Yalom (1991). Those include idealization and devaluation, tendency to externalize, compensatory tendencies, and tendency to con or

avoid. Clinicians need to confront and challenge these behaviors that are considered inconsistent with recovery. At the same time, clinicians must consider the possible consequences of a confrontational approach and be able to switch to a more supportive posture when necessary. Using a balance of confrontation and support, a therapist must also find a way to be both empathetic and distrustful of the chemically dependent client who may return to drinking or drug use at any time.

The Significance of Aftercare

In a review of the literature focusing on aftercare following treatment for alcoholism Ito and Donovan (1986) identified aftercare as a significant component of the treatment process. Aftercare is designed to help clients maintain therapeutic gains achieved in primary treatment. Maintenance was defined as an active stage of change rather than absence of change. The results of this review suggest that aftercare attendance leads to improved treatment outcome. That is, aftercare is more strongly related to improved drinking status than abstinence rates.

Rohsenow, Childress, Monti, Niaura, and Abrams (1991) describe the period following primary treatment as unsettled in that it is typical for clients to experiment with the recovery process. Relapse is common as are periods of abstinence and attempts at controlled drinking or drug use.

Ito and Donovan (1986) and Vannicelli (1988) report that early detection of the relapse process is an important function of aftercare. Relapse is viewed as opportunity to intervene so as to interrupt the relapse process rather than failure of treatment. The belief is that if relapse is addressed quickly and appropriately in the group that it can be a useful learning experience. It can help the client to identify difficult issues that need to be addressed. It can serve as a reminder to other group members for continued vigilance in their own recovery process (Vannicelli, 1988).

Summary of the Literature

Extensive literature on treatment of chemically dependent clients indicates that interactional group therapy, when modified, can be an effective method of treatment.

The literature on group therapy reveals that group therapy is made up of several developmental stages with some, known as the working stages, being more conducive to change than others.

Literature on aftercare recognizes it as a significant component in helping to maintain changes addressed in primary treatment and in improving drinking or drug using status following primary treatment. It was suggested in the literature that research be conducted uncovering manipulable factors that might predict aftercare attendance.

There was no such literature regarding frequency in particular group stages as a predictor of aftercare attendance. This study is an attempt to determine if greater frequency in a working stage, while in primary treatment, can be considered a manipulable factor predicting aftercare attendance following primary treatment.

CHAPTER III

METHODS AND ANALYSES

Introduction

This chapter contains a discussion of participants that were used in this study, the method used for obtaining the data, and the analysis of the data.

Participants

Data for this study was collected on 103 clients who were consecutive admissions to the Alcohol and Drug Recovery Center outpatient office between the dates of July 1, 1992 and February 28, 1993 for treatment of chemical dependence. Participants were both male and female. They were black, white, or native american. Participants ranged in age from 20 to 64. Each client was given a specific psychiatric diagnosis based on the DSM III-R and voluntarily entered treatment at this facility. Thirty-seven of the 103 clients successfully completed primary treatment and were referred for aftercare. Results of this study are representative of those 37 clients that were referred for aftercare.

Methods

Data for analysis includes examining the number of times each client reached a working stage of group therapy while in primary treatment and whether or not those clients

were referred to and completed at least 6 months of aftercare.

Data were collected on each of the 103 clients until they were discharged from primary treatment or aftercare. Data on group stage were usually rated and recorded by the staff psychologist immediately following each group therapy session while the client was in primary treatment. When the staff psychologist was not in the group the rating was made by one of the staff counselors. The data were recorded on the Group Process Recording Sheet included in this report as Appendix A.

In order to assess the reliability of the ratings by the staff psychologist, the two staff counselors each rated 30 group sessions independently of the psychologist. This data, and that of the psychologist, were collected and recorded on the Inter-Rater Agreement Recording Form included in this report as Appendix B. The results of that assessment are included in the results section included in Chapter IV.

Data on aftercare attendance were recorded in the client's medical record following each session.

Statistical Design and Analyses

The independent variable in this study is the assignment of clients into one of two categories based on the number of working stages that they participated in while

in primary treatment. Those clients who participated in less than 10 working stage groups were placed in one category and those clients participating in 10 or more working groups were placed in another group.

The value of 10 was determined after calculating the mean number of working groups that each of the 37 clients participated in which was 9.38 and determining the median number of groups which was equal to 10.

The dependent variable in this study was whether or not a client completed at least 6 months of aftercare following primary treatment. Six months participation is defined as participation in at least 23 group therapy sessions. This number was chosen to allow for absences due to illness, vacation, or closing of the treatment facility for holidays.

A chi square test was used to analyze the data for this study to determine if results are different from chance. The inter-rater agreement was assessed by dividing the number of agreements, between the counselor and psychlogist, by the total number of groups observed by them both. The number was multiplied by 100 to obtain a percentage of agreement between the psychologist and the counselor.

CHAPTER IV

PRESENTATION OF RESULTS

Introduction

This chapter reports the analysis of data. The chi square test was employed to determine if there is a significant difference between the two groups. The results are described in Table 1. Results regarding reliability are reported in this chapter and are shown in Tables 2 & 3. Chi square data is shown in Table 4.

Hypothesis

Those clients in primary treatment of chemical dependence who reach a working stage in group therapy with greater frequency than those clients who do not while in primary treatment are more likely to complete six months of aftercare.

Results

The results of the chi square, 1.33, failed to reveal a significant difference between the two groups of subjects at the .05 level of significance which is equal to 3.84. The hypothesis is rejected. The chi square table regarding aftercare attendance is presented in Table 4.

Data collected on those 37 clients who were referred to aftercare are presented in Table 1. Eighteen of those 37

Table 1

Aftercare Attendance

Group[a]	<6 Months[b]	≥6 Months[c]
<10 Working Groups	9	9
≥10 Working Groups	13	6

[a]n = 37

[b]n = 22

[c]n = 15

Table 2

Inter-Rater Agreement for Classification of a Working Stage

	Counselor 1	
Psychologist	Working Stage	Non-Working Stage
Working Stage	5	2
Non-Working Stage	0	23

Note. N (total) = 30

Table 3

Inter-Rater Agreement for Classification of a Working Stage

	Counselor 2	
Psychologist	Working Stage	Non-Working Stage
Working Stage	6	0
Non-Working Stage	3	21

Note. N = 30

Table 4

Chi Square Table of Aftercare Attendance

Group	<6 Months		≥6 Months	
	Observed	Expected	Observed	Expected
<10 Working Groups	9	11	9	7.5
≥10 Working Groups	13	11	6	7.5
Totals	22	22	15	15

clients participated in less than ten working groups while in primary treatment. Nine of those 18 clients did complete 6 months of aftercare and 9 of those clients did not. Of the 19 clients participating in 10 or more working groups while in primary treatment, 6 completed 6 months of aftercare and 13 did not. Of the 37 clients referred for aftercare, 15 completed at least 6 months of aftercare and 13 of those clients went on to complete one year of aftercare.

The results of rating the group therapy sessions regarding group stages between the psychologist and the two staff counselors reveal a high level of inter-rater agreement. Ratings between the writer, who is called Counselor 1 in this study, and the psychologist on 30 groups is at 93%. Ratings between Counselor 2, and the psychologist on 30 different groups is 90%.

CHAPTER V

FINDINGS, CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS

Introduction

This chapter contains the findings and conclusions of the study with recommendations for further research.

Findings and Conclusions

The hypothesis proposing that those group members who participated in more working groups were more likely to complete at least 6 months of aftercare than those who did not rejected. Therefore, according to this data, participation in a greater frequency of working groups is not a manipulable factor that predicts completion of aftercare.

Discussion

In light of the results it appears that participation in a higher frequency of working groups does not stand alone as a predictor of aftercare attendance. It seems likely to this writer that participation in a significant number of working groups does have some effect on clients that would make it more likely for them to participate in other similar groups. This seems likely because more of the curative factors, noted by Yalom (1985), are more likely to manifest themselves in groups that are more mature.

One possibility for the rejection of the hypothesis is that the study was conducted on an open group, that is, the membership changes continually. Groups were frequently interrupted by members entering the group and others terminating. Corey & Corey, (1987) describe groups as regressing at times and report that members frequently return to old behaviors when a group member is terminating. Yalom, (1985) recognizes turnover in group membership as an important consideration requiring careful planning, whenever possible, so as not to disrupt the group too greatly.

Another possibility for the rejection of the hypothesis is the brevity of primary treatment. Group members, even though they reach a working stage frequently, may have difficulty developing a level of trust that would permit them to honestly express themselves among their peers. Because relapse is common in work with a chemically dependent population, group members may find it difficult to trust their peers who might relapse at any time (Flores, 1988). Group members may not have sufficient time in primary treatment to address their lack of trust and thus may never realize the benefit of continued work in a group.

Another possibility for the rejection of the hypothesis is that group members frequently feel like they have been "cured" once they complete primary treatment. Group members, upon completion of primary treatment, participate in a graduation ceremony that signals the end of that phase

of their treatment. Members who have benefitted more from the therapy sessions in primary treatment may decide that they have addressed their pertinent issues in that phase of treatment. Their perception may be that they are managing their sobriety exceptionally well and are therefore ready to try things on their own rather than to continue with aftercare.

Recommendations

Out of this research come a number of recommendations that may reveal other findings regarding the relationship between participation in a larger number of working groups and aftercare attendance. First of all, I strongly recommend that this study be modified and replicated using a closed group over a longer period of time in order to permit the curative factors, described by Yalom (1985), to manifest themselves in the group and to allow group members ample and equal opportunity to gain full benefit of a working group.

Another recommendation is to increase the reliability of the study by having observers who are not involved in the group rate and record the perceived group stages.

Numerous possibilities exist as to why the hypothesis was rejected. The examination of other variables in conjunction with greater frequency in working groups may help to uncover manipulable factors which help to predict

aftercare attendance.

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APPENDIXES

APPENDIX A

GROUP PROCESS RECORDING SHEET

Subject Number	form	storm	norm 1*	norm 2*	tran *	term	conf

Note. * denotes working stages

APPENDIX B

INTER-RATER AGREEMENT RECORDING FORM

Psychologist Rating / Counselor Rating

	form	storm	norm 1*	norm 2*	tran *	term	conf
form							
storm							
norm 1*							
norm 2*							
tran*							
term							
conf							

Note. * denotes working stages

VITA

Lynn Beaman English was born in Asheville, North Carolina on April 4, 1958. She attended school in Asheville and obtained her General Equivalency Diploma in 1976. In 1981 she moved to Knoxville, Tennessee and began her undergraduate education at the University of Tennessee. She received her Bachelor of Arts in General Psychology in March, 1988. She began her graduate course work in 1989 in the College of Education. She is working toward completion of her Master of Science in Educational Psychology.

Ms. English began her employment with the Alcohol and Drug Recovery Center at University of Tennessee Medical Center in 1988. She continues in her full time employment as a counselor at that facility. She has received both state and national certification as a substance abuse counselor.