Leading Psychoeducational Groups: The Nurse's Role

Office of Nursing Services (ONS) Mental Health Field Advisory Committee

Revision 2015

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Table of Contents

Introduction……..6

Module 1……..11

Module 2……16

Module 3……24

Module 4……..32

Module 5……..38

Tool Kit……47

Website and Resources……67

Introduction

Objectives

You will be able to:

1. Discuss the purpose of this Group Guide.
2. Distinguish between psycho-educational groups and other group modalities.
3. Identify ethical considerations when conducting psycho-education groups.

Key Concepts

Why groups are an important treatment modality.

Types of groups offered in the Mental Health Setting.

Psycho-education versus psychotherapy groups

Ethical guidelines when designing and conducting groups

Rationale for Development of the Group Guide Manual

The revised American Nurses' Association Psychiatric Mental Health Nursing: Scope and Standards of Practice (2014) has affirmed the nursing roles of educator and manager of the therapeutic milieu. For nurses seeking certification by the American Nurses' Credentialing Center (ANCC), as a psychiatric mental health nurse generalist, knowledge and application of group process is vital.

More recently, the American Psychiatric Nurses Association (APNA), International Society of Psychiatric Nurses (ISPN) and the American Association of Colleges of Nursing (AACN) have collaborated to develop detailed competencies essential for psychiatric mental health nursing practice. Members of those organizations have identified education in milieu and group facilitation as essential for professional nursing practice notwithstanding the designated nursing specialty.

Facilitation of therapeutic groups by nurses has been part of psychiatric nursing practice for decades. Despite the continual expansion of evidence-based knowledge, the value of group education and treatment remains a critical component of a dynamic therapeutic environment.

This manual is presented to assist staff nurses in developing effective psycho-educational groups as part of his or her mental health nursing practice.

A Definition of the term "Group" and Types of Therapeutic Groups

The term therapeutic group can refer to many types of groups that have therapeutic intent. According to Boyd (2012) "a group is two or more people who develop interactive relationships and share at least one common goal or issue. A group is more than the sum of its parts. A group develops its own personality, patterns of interaction, and rules of behavior" (p. 195). Depending on its type, groups can be conducted by professional and non-professional staff members. Different types of therapeutic groups include but are not limited to: Community Meetings, socialization groups, activity/task completion groups, support groups, skills building groups, and psycho-educational groups. Mental health treatment programs offer a variety of groups that are generally categorized as:

Activity Groups: these groups include exercise, manual tasks, crafts or leisure-oriented activities or outings.

Community Groups: Community re-entry meetings, family/friend liaison/relationships or program-based community issues.

Psychotherapeutic Groups: these groups focus on identification and/or exploration and resolution of intra-psychic conflicts.

Psycho-educational Groups: these groups support teaching of physical health and mental health education for effective living, problem management and mental health recovery.

**** Throughout this Guide, PE will refer to psycho-educational.***

Therapeutic Groups and Group Psychotherapy

It is important to differentiate group psychotherapy from the other therapeutic groups. An interdisciplinary organization, The American Group Psychotherapy Association (AGPA) defines group psychotherapy as a "special form of therapy in which a small number of people meet together under the guidance of a professionally trained therapist to help themselves and one another" (n.d.). Group psychotherapy has an interpersonal focus and is conducted by Advanced Practice Nurses and other Master's or Doctoral prepared Providers who have

specialized preparation and participate in ongoing supervision. The AGPA has developed general standards for conducting group psychotherapy along with certification process for group psychotherapists (AGPA, n.d.). This table summarizes the differences.

Criterion	Group Psychotherapy	Psycho-education Groups
Focus of the Group	Interpersonal and Experiential	Education of a specific topic
Group Process	Improvement or resolution of interpersonal issues	Knowledge gained Skills Training
Leader preparation	Advanced Practice Nurses, Certified or Doctorally-prepared Providers	Professional or Nonprofessional Staff

Psycho-educational Groups as the Modality of Choice for Professional Nurses

While many types of therapeutic groups can be offered by non-professional staff such as Mental Health Technicians, psycho-educational groups require professional expertise and knowledge of the subject being taught. Nurses already have a strong knowledge base regarding illness, wellness, health promotion, health alteration, disease, and treatment of health-related issues. Conducting psycho-educational groups also requires skill in both leadership and group dynamics. This Guide is intended to support the professional staff nurse in developing psycho-educational group skills.

Ethical Issues in Group Work

The Association for Specialist in Group Work (1990) identified sixteen guidelines that need to be considered when designing and conducting groups. Of the sixteen guidelines, Orientation, Screening and Confidentiality are necessary for group work preparation:

Orientation: this is the provision of information on both the subject matter and group format prior to the group's beginning.

Screening: determines the suitability of individuals for participation in the group, level of the potential group member's functioning and relevance of the topic to the group member.

Confidentiality: this is to assure participants that their input will not be discussed with anyone other than relevant and necessary members of the treatment team.

Confidentiality and group orientation should be discussed prior to the beginning of the group's formation or at the beginning of the first group held. During the group session,

members that express verbalizations that represent a danger to self or others will be reported to the appropriate treatment providers.

In addition to the abovementioned guidelines that are vital to group work, the following table illustrates additional ethical issues that can alter the group process. It is important for the professional nurse to be aware of ethical considerations when planning and conducting group work.

Issue	**Definition**
Participation	Can be voluntary or involuntary, includes freedom to exist.
Coercion and Pressure	Can occur from other group members and can undermine the group's function.
Leaving the Group	Particularly problematic in an ongoing group.
Dual Relationships	Leading a group that also contains a peer or subordinate.
Counselor Values	Not imposing the counselor's values into the group.
Equitable Treatment	Regardless of group members' diversity or leader bias, extensive levels of self-awareness and self-examination on the part of the leader are necessary.
Use of Techniques	Depends on the competency and specific training that the leader has received in a given category or skills that can then be generalized.
Goal Development	Goals are more relevant if they are patient-centered. May be set by the group leader but will have greater impact if they are congruent with the group members' goals.
Consultation	May be necessary between group leaders, supervisors or peer mentors. Group members need to determine which forms of communication will be used outside the group setting.
Member Termination	Must be an option in the case of group disruption, violence or abuse. This needs to be done when considering both the needs of the member and the remaining group members
Evaluation and Follow-Up	Often omitted in the group planning. Group leaders have a responsibility to obtain feedback whenever possible on the effectiveness/impact of the group.
Referral	Group leaders should be well informed on available community resources. Resources should be brought to group meetings routinely.
Continued Expertise and Professional Development	Leaders must take personal responsibility for assuring that he or she has adequate training in group leadership skills. The leader's knowledge and expertise continues to increase through structured, systematic professional development.

Psycho-educational groups require the leader to possess skills in both group leadership and group process. This group work also requires professional expertise and knowledge of the

topic being taught. Nurses possess extensive knowledge and have the unique ability to educate health care consumers about issues of health, wellness, and mental health recovery.

Let's get started.

✓	Knowledge Check
	I can define the essential characteristics of a group.
	I can identify the purpose of the Group Guide.
	I can differentiate between the psycho-education group and a psychotherapy group.
	I know the types of groups available in the mental health setting.
	I am familiar with the remaining ethical guidelines that can alter group dynamics.
	I know the three essential ethical guidelines necessary to establishing a group offering

Module 1 – Conceptual Frameworks

Objectives:

You will be able to:

1. Describe recovery principles
2. Differentiate therapeutic milieu from milieu therapy
3. Discuss the therapeutic factors common to psycho-educational groups

Key Concepts

The recovery model is the supporting framework for psychiatric nursing

Psycho-educational groups take place within the context of a therapeutic milieu

The environment of a residential or outpatient setting has the potential for therapeutic value

Common therapeutic factors emerge from various types of groups

What is Recovery?

The recovery framework has been widely accepted in mental health systems and is being integrated into nursing curriculums. It is also emphasized in the new edition of *Psychiatric Mental Health Nursing Scope and Standards of Practice* (2014). A key component is the inclusion of consumers of care into all decisions.

The Substance Abuse and Mental Health Services Administration (SAMSHA, 2011) suggests the following definition:

> Recovery from mental health disorders and substance use disorders is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMSHA further describes four major dimensions of recovery:

1. **Health**: Overcoming or managing one's disease as well as living in a physically and emotionally healthy way.
2. **Home**: A stable and safe place to live.

3. **Purpose**: Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
4. **Community**: Relationships and social networks that provide support, friendship, love and hope.

Within this framework, the environment of care is designed to promote the achievement of goals in the four dimensions. The Standards further articulate the nurse's role in providing a recovery-oriented therapeutic milieu.

Therapeutic Milieu Functions

Groups conducted in outpatient settings are usually part of a larger clinical program, but are often independent of other activities in a clinic. This differs from inpatient settings where groups take place in the larger context of a living learning environment. This purposefully designed environment is called a therapeutic milieu. Nurses, by virtue of their 24 hour presence, are managers of this environment, whether deliberately or by default.

It is important to distinguish therapeutic milieu from milieu therapy. The term therapeutic milieu is used in this guide, not to describe a form of therapy, but to describe the context within which therapeutic groups can take place.

Five processes of the therapeutic milieu were identified by Gunderson (1978) and reconceptualized for nursing by LeCuyer (1992). They continue to be useful conceptual tools. Once these processes are understood, unit procedures and dynamics can be assessed within the model.

The five processes are as follows:

Milieu Process	Function
Safety	Patient safety and physical security are provided by the therapeutic milieu. External safeguards include regulation informed policies, quality indicators such as Environment of care and structural requirements of accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations. Unit policies for trauma informed use of restraint and staff training in de-escalation and therapeutic holding are expressions of this
Milieu Process	**Function**
Support	By offering assistance and assurance, support consists of efforts to provide patients with comfort and security. Support includes concrete provisions such as an aesthetically pleasing physical environment, nourishing food and availability of clothing. Access to medical and social services, assisting the patient toward independence, is also included.
Structure	All aspects of the environment that provide predictability such as schedules, assignments, and consistency represent the function of structure. While guidelines and consequences are safety measures, clarity of these guidelines and consequences is structure. Therapeutic groups involve planning for staff and space and cannot occur without structure. The community meeting is an excellent vehicle for reinforcing structure.
Social Involvement	Any intervention that promotes interpersonal interaction is an example of social involvement. These interventions can be individual sessions, therapeutic groups or social activities. It also pertains to the Veterans' participation in his or her treatment plan, as well as the ability to participate in unit planning.
Self-Understanding **Validation**	Validation is any intervention that affirms the uniqueness of the individual. It is a core principle of the Recovery Model. Patients are not labeled or dehumanized in any way, all contributions are acknowledged. Treatment plans are individualized, identify strengths and competencies and give opportunities for individual expression.

Therapeutic Factors of Group Treatment

Yalom's classic work, *The Theory and Practice of Group Psychotherapy*, was first published in 1970. In the current, fifth edition (Yalom, 2005), he acknowledged the difference between classic group psychotherapy and the myriad forms of group treatment and education. Yalom emphasized that the core of the work, the eleven therapeutic factors below, are

applicable to all types of therapeutic groups. Brown (2011) has identified which of the factors are most likely to appear in psycho-educational (PE) groups and which factors are limited.

“Most likely to appear" factors:

- **Universality:** In a group, members learn that they are not alone in their experience. This reduces feelings of isolation and alienation. Veterans have common characteristics as well as common issues they are facing. Veterans say they feel more comfortable in a group of fellow Veterans. They feel they do not have to explain anything; other Veterans “get it”.
- **Altruism:** By definition, something is given or offered without expectation of anything in return. As patients help each other, they begin to value themselves as people who have something to offer.
- **Imitative behavior:** Facilitators can serve as positive role models for group members. This is especially important in supportive groups where members will copy supportive behaviors. Many PE groups use role playing as a learning strategy.
- **Imparting of information:** This concept includes didactic instruction from the facilitator as well as guidance from other members. Giving information is a major objective of PE groups.

“Likely to appear” factors:

- **Instillation of hope:** Group members experience hope by seeing others improve. This is a key factor in the effectiveness of 12 step groups. In any given group, there are members in various stages of recovery.
- **Development of socializing techniques:** This can be a focus of a PE group or an indirect benefit. In evidence-based social skills groups, communication and attending skills are introduced, modeled, and practiced. In other types of PE groups, members may break into dyads and be able to have structured, short conversations.

- **Interpersonal learning:** This may not be a focus of PE groups, as members do not usually give feedback to each other. In groups such as anger management and parenting, feedback about interactional style can be a focus.
- **Group cohesiveness:** Veterans share several characteristics and can readily become cohesive. Group cohesiveness results in members feeling a sense of value, belonging, acceptance and support by others. A concern occurs when subgroups form and become "cliques", excluding those who do not share a certain characteristic. Group leaders can build cohesion by exercising skills to connect members to each other.

"Limited appearance" factors:

- **Corrective recapitulation of primary family:** Purposeful nurturing of this dynamic is reserved for psychotherapy groups. However, positive relationships with the leader and members form in PE groups, as well. If these relationships are positive, they may contrast with dysfunctional family patterns.
- **Catharsis:** Psycho-educational groups are not designed to promote personal venting and expression of negative affect. Anger management group would be an exception. These groups are typically conducted over a period of several weeks and are structured for safe expression of affect.
- **Existential factors:** Examples of existential content would include facing life alone, living in an unjust world and taking responsibility. These issues occur in long term psychotherapy groups and are explored as part of recovery support groups.

✓	Knowledge Check
	I understand the concept of recovery and can describe the four dimensions
	I can give examples of the five therapeutic milieu functions from my practice
	I know which therapeutic factors of group are most evident in psycho-educational groups

Module 2 – Group Process and Dynamics

Objectives

You will be able to:

1. Describe the stages of group process and development
2. Identify three elements that distinguish psycho-educational groups from therapy/counseling groups
3. Respond therapeutically to group dynamics

Key Concepts

Nurses develop and lead groups in a variety of settings for a variety of purposes

Group development occurs in stages

Group dynamics are subtle and can have significant impact on the success of a group

Group cohesiveness is a fluid process

Goals for the group should be identified early in the process

Successful groups result in benefits for each member

Types of Groups

Mental health nurses are increasingly called upon to develop and lead patient groups in a variety of settings. It is essential that the mental health nurse exhibit competence in recognizing the different functions of groups, while also being aware of his or her own role as group leader. The group leader, with active participation of the interdisciplinary team and the Veteran, determine the character of the group, and distinguishes the group purpose and goals.

A group can be defined as a "collection of persons who come together in some way that makes them interdependent" (Frisch & Frisch, 2002, p. 687). Therapy or counseling groups are groups that receive psychotherapy in a group setting. Supportive groups assist members in dealing with emotional stresses due to hospitalization, recreation, educational, reality orientation, and reminiscence. Nurses often lead educational, supportive therapy or problem-solving groups. Inpatient units offer a variety of groups that are generally categorized as:

- **Activity groups:** include physical exercise manual task/craft/leisure oriented activities or outings
- **Community groups:** community re-entry related meetings, family/friend/liaison/relationships, or ward/community issues
- **Psychotherapeutic groups:** work toward identification and/or exploration/resolution of intra-psychic conflicts
- **Psycho-educational groups:** support teaching of physical health and mental health information for effective living, problem management, and recovery

The focus of this publication is psycho-educational (PE) groups. Brown (2011) stated that the function of PE groups is educational, with a target on skills training. Brown delineated the differences between psycho-educational and counseling/therapy (psychotherapeutic) groups by focusing on specific elements to include:

Specific Elements of Psycho-educational Groups	
Emphasis on didactic instruction	No screening of members
Emphasis is on task functions	Self-disclosure accepted but not required
Leader operates as facilitator, teacher	No particular emphasis on confidentiality
Sessions cam be as few as one	Group size can be large
Focus on prevention	Use of planned, structured activities
Goals usually defined by leader	(Brown, 2011, pg. 10)

In order for PE groups to be utilized effectively in an inpatient psychiatric setting, they must have specific characteristics (Clark, 1994; Lego, 1998; Potter et al., 2004; Yalom, 2005):

Characteristics of Psycho-educational Groups	
Structure	Present meaningful information
The immediate needs of the patients must be assessed	Evidence of collaboration between patients and nurses
As group progresses, individual needs of participants must be assessed	An understanding of the underlying causes of behavior
Active learning model on the part of the nurse, which demonstrates the nurse's quest for enhanced group leadership skills with an understanding of group dynamics and stages as an ongoing process	

Stages of Group Development

There are various stages of groups or group movement. Group leaders should be aware of and know how to maneuver through various stages of group formation in order to be successful. They should be able to listen to what is going on in the group and be able to recognize the stage of group functioning. LaSalle and LaSalle (2005) emphasize that achieving a balance in group leadership expertise entails merging skills and judgment through continued practice in leading group, while being supervised by experienced group facilitators and by learning the group process.

The nomenclature and description for stages of groups are varied and have evolved over the years. Tuckman (1965) described group development as forming, storming, norming, and performing. Yalom (2005) delineated the same stages as orientation, conflict, cohesive, and working. Clark (1994) identified a system concerning phases of group movement including the orientation, working, and termination phases. They all gave similar definition, task activity, and interpersonal activity for their stages. Clark (1994) gave suggestions that nurse leaders could utilize to guide a group through each phase.

The orientation or **forming** stage primarily revolves around the identification of tasks, boundaries, and relationships between leader(s), group members, or cultural norms. Successful movement through the orientation phase often requires more active participation from the leader, as there may be uncertainty and insecurity exhibited by group members during this phase. It is essential that the group leader set realistic goals during this phase. The leader helps move the group beyond the orientation phase by modeling open communication patterns. Leaders may summarize group sessions and ask for suggestions for future topics, as group members will often not take the initiative to do so.

The working phase includes the conflict or **storming** stage, which focuses on the emotional response to the task and the cohesive or **norming** stage, which ensures emotional overtones are overcome and cohesiveness is developed. During the working phase, the group focuses less on the leader as the group members become more efficient and independent problem solvers. Clark stated, “Nurse Leaders function most effectively in this stage by helping the group from getting sidetracked, encouraging problem-solving and consensus decision

making. There is less need to reinforce ground roles or provide support for group members. An overprotective or over-controlling group leader can influence whether a group is able to fully mature or not. Effective leaders act very much like group members and effective group members act like group leaders in this phase" (1994, p. 62).

In the working or **performing** stage, energy is geared toward the completion of the task. This final stage is identified as adjourn (Tuckman & Jensen, 1977) or the termination phase (Clark, 1994; Yalom, 2005), and is an essential component of any psycho-educational group. The group leader needs to be knowledgeable concerning the tasks associated with the termination phase. Unfortunately due to time constraints, this phase is often overlooked by the nurse leader. Yalom (2005) suggested the following process be included in the termination phase; summarization (can be done by both the facilitator and group members), assignment of homework (if indicated), request for future topics, and encouragement of feedback by group members.

A 60-minute psycho-educational group needs approximately 10 to 15 minutes dedicated to **termination**. The group leader should foster group evaluation by initiating summarization and actively encouraging member feedback. The goal of termination is for the group members to feel a sense of completion about the group session and apply group experiences to life situations.

It is important to remember that all the group stages may be condensed, within a single group session, on an inpatient psychiatric unit. Nurse evaluation of PE groups is an ongoing process. The enclosed Tool Kit includes a checklist for evaluation of PE groups and tools to document group notes in CPRS.

Group Process

Group process "refers to the way group members interact with one another" (Clark, 1994, p. 21). Group leaders must be aware that these group processes are occurring and be able to identify what the process is and how it is either impeding or enhancing the process of the group. It is important for the leader to focus on the "here and now" aspects of the group process and try to discern what rules of behavior are in operation or what factors are enhancing or impeding the achievement of the group goals.

It is generally accepted that there are rules for expected behavior within a group, referred to as norms. Norms are brought into the group or created from within, based on already existing cultural values, beliefs, or customs. Understanding the presence of norms is important, due to the impact on group cohesiveness. The establishment of group norms identifies guidelines for acceptable or unacceptable behaviors. Toseland (1995) and Yalom (2005) gave the following suggestions about the establishment of norms:

- Group norms should be established early and should include input from group members
- Norms should be clearly stated. A group can become too passive if norms are not established
- Norms should be reviewed periodically
- Group members should be held accountable for adhering to the established norms
- Norms should only be changed with the input of group members

Yalom (2005) stressed that groups exhibit a more cohesive nature if the norms are valued and protected.

Group Dynamics

Group dynamics often impact the success of groups. The leader's ability to effectively identify and progress through each of these dynamics becomes easier with practice and is essential to effectively lead groups. Brown (2011) gave an explanation of group dynamics:

- **Level of participation:** It is through close observation of the intensity, type, and extent of the group members' interaction with each other, that the leader can assess the needs of the members. The ebb and flow of the interactional patterns should be used by the group leader to indicate the stage of the group progression.

- **Resistance:** Opposition to the group process can range from mild to intense and can serve as a useful function in the group process. If the group leader observes that the entire group is resisting participation in the psycho-education group, the leader needs to consider a change in topic or length of time for the group.

- **Communication patterns:** Not only must the group leader be aware of the interaction among group members, but should also observe how group members are interacting with the group leader. These communication patterns should be observed over the life

of the group to give a true picture of the pattern, rather than relying on a single incident.

- **Relationships:** Initially the group leader is viewed as the expert by the group members. It is essential that relationships among group members are fostered because it is from these relationships that real growth and learning occur.
- **Nonverbal behaviors:** Nonverbal behaviors, called meta-communication, often provide a more accurate reflection of the emotional patterns that are evolving in the group. Experienced group leaders often rely on the interpretation of nonverbal behaviors to give a more accurate depiction of the group's progress.
- **Feeling tone:** Continued personal Development of the group leader is essential to increasing the effectiveness of the leader. Consistent self-reflection of the leader helps to gauge the feeling tome of the group. A group's progress can be obstructed by a group leader who is unable to assess the areas needing improvement in facilitation of group process.
- **Aroused/Expressed feeling:** Often feelings that have been suppressed by group members are brought to the forefront by the group process in either direct or indirect ways. It is important for the group leader to recognize that these types of aroused/expressed feelings should be addressed in counseling or in a therapy group setting and not in the psycho-educational group setting.

Group Cohesiveness

Group cohesiveness has three dimensions that bring about change in group members:

- **Group identification:** reflects the essential nature of the group
- **Acceptance:** members' acceptance of each other
- **Support:** enhances the feeling of reassurance that members experience

Yalom (2005) emphasized that group cohesiveness is a fluid process. It is important to remember that many psychiatric patients, by nature of their past experiences, do not have a history of group participation. That fact alone can enhance the value of the group experience for that person (2005). It is essential for the leader to be aware that group

members may have to be brought to this cohesive stage for the group experience to be productive (Bloch & Crouch, 1985; Lego, 1998; MacKenzie, 1990).

Yalom (2005) suggested factors that leaders of inpatient groups must consider. Reasonable and attainable goals must be set, which are appropriate to the clinical setting and time frame. An understanding of the underlying psychopathology of each group member is essential. Exclusion from group based on the degree of manic or psychotic behaviors may prove to be therapeutic, both for the group and for the individual. There must be a focus on the present. Structure is a very important aspect of a group, as the group experience may only last one session. Yalom stated that for the inpatient setting, "structured protocol for each session helps to ameliorate anxiety and confusion (1983, p. 280).

Goals of Group

The tasks and knowledge of the group leader are many and varied. Yalom cited four goals of inpatient psychotherapy groups for the group leader; the first three pertain to PE groups (2005):

- To help patients learn the benefit of discussing problems within a group setting
- To relieve any anxieties about hospitalization
- To identify problems within areas of their interpersonal functioning
- To assist patients to engage in therapy

Brown cited four desired outcomes for members in PE groups (2011):

- To learn new information
- To acquire new skills and/or increase skills
- To discover alternative ways of communicating and/or relating to others
- To enhance self-management skills and personal development

Corey (2000) added that PE groups not only increase participants' awareness of life problems, but can also provide tools for better management of life problems. In addition, members experience universality as they hear within the group express similar problems.

Benefits of Group

As members help each other within the group, they increase their feelings of self-worth and self-esteem. Six benefits of PE groups for members are:

- An increase in participants' involvement in managing their illness
- An increase in communication and sharing with others, first within the group and later outside group
- Increased recognition of problems, with the development and implementation strategies to solve them
- Decrease in isolation and feelings of loneliness
- Giving and/or receiving peer support, with validation from peers
- Reduction in anxiety levels

PE groups help members improve their quality of life and learn about their illness and symptom management. It is important that the group leader keep all of these issues in mind as he/she plans for and implements an inpatient PE group.

✓	Knowledge Check
	I know there is a difference in types of groups including: - Activity groups - Community groups - Psychotherapeutic groups - Psycho-educational groups
	I know and understand the eleven specific elements of psycho-educational groups
	I know and understand the seven characteristics of psycho-educational groups
	I know there are stages of group development, including forming, storming, norming, performing, and termination
	I know and understand group processes, especially the importance of defining the group norms early in the group process
	I know and understand the impact of the seven contributing factors to group dynamics
	I know and understand the three dimensions of group cohesiveness, including group identification, acceptance, and support
	I know and understand four goals of inpatient psychotherapy groups and four desired outcomes for members in PE groups

Module 3 – Group Leadership

Objectives

You will be able to:

1. Apply basic principles of teaching and learning to group process.
2. List essential characteristics of a group leader.
3. Utilize therapeutic communication skills in groups.

Key Concepts

Principles of teaching and learning

Effective leadership characteristics

Therapeutic communication skills of group leaders

Faulty leadership strategies used by group leaders

Basic Principles of Teaching and Learning within Psycho-education Groups

Education on a particular topic is the primary purpose of any psycho-educational group. The group leader presents information through teaching, discussion, observation or participation. Keep in mind that members who are quietly observing or listening are also actively participating in the group process and can gain new ideas, facts or concepts from this group experience. Secondary learning takes place as participants see and experience how the leader and members interact with each other. Both primary and secondary learning assists participants in gaining knowledge and resources for managing the many challenges they face in their daily lives.

The composition of inpatient groups changes daily due to admissions, discharges, changes in acuity levels, and responses to medication adjustments. The frequency of these changes makes each group different from others before or after it. Structure within each group is necessary to assure members' safety, trust, acceptance, and role modeling of appropriate group behavior.

Education on a particular topic is the primary purpose of a psycho-education (PE) group. Clark (1994) cited two types of leadership functions for group work: (1) **task** and (2)

maintenance. Task functions are defined as getting the group started, keeping the discussion moving, and clarifying any unclear comments. To illustrate clarification: "I'm not sure I understand what you are saying." "Can you say it another way?" Reflecting your understanding back to the speaker can also be helpful and then asking if it is correct: "I hear you saying. . ." "Is this correct?" If it is, then restating the member's response more clearly for other group members to hear it in another way corrects the unclear communication. Additional task functions can include having handouts, using a dry erase board or blackboard to list important points and using pertinent examples are all important methods for conveying information in multiple ways.

Maintenance functions help participants improve interpersonal relationships among the group members. This can take the form of supporting members in group who may be anxious or uncertain, decrease tension within and among group members, and agreeing with or accepting what is said within the group. The group member must be aware that the group itself is an entity; just as each individual member is an entity.

All psycho-education groups have a chosen focus and content. Psycho-education groups require that the leader knows how to lead a group as well as how to teach content. The group leader chooses the topic of focus as well as the method of presentation. **The goal of psycho-education groups is to teach participants specific information, and practice strategies or skills.** The group leader needs to develop an instructional strategy to maximize the group members' learning. The educational component of the PE group is significant and typically has the most emphasis. Topics that can be taught independently within the session are important for psycho-education groups in either the inpatient or outpatient setting. The leader must: (1) develop and state goals for the group, as well as (2) determine the method of teaching based on members' needs and characteristics. Age, maturation and educational level play a role in the group member's ability to learn.

The level of anxiety experienced by group members influences their ability to learn and retain information. It is important to spend some time at the beginning of each group to help members feel included, valued, and relaxed. Warm-Up exercises such as name introductions, introducing you as the leader, and reviewing with the participants what the group hopes to

accomplish establishes a level of trust and acceptance. It also helps members to understand the expectations for the group session.

Individuals are motivated to learn if the material has meaning for them. Organizing the material ahead of time and relating it to previous group topics can be beneficial to members. Material must not only be learned but also retained by the group participants. Material with high meaningfulness to the learner will be retained and utilized in everyday activities. Topics of sleep, mood, mental health problems, medications, and problem solving skills are topics that all members can find relevant and understand.

Educational content is more likely to be retained if the following concepts are applied:

- ✓ **It has meaning and importance for the learner.**
- ✓ **The learner does not have a trauma, learning disability, or distraction that would interfere with the learning.**
- ✓ **The content is applied to real life situations after being learned ("Use it or lose it").**
- ✓ **Homework exercises are used as a means of reinforcing the learned material.**
- ✓ **The learner is physically and psychologically able to learn and retrieve material that is presented.**

Effective Leadership Characteristics

The Association for Specialists in Group Work (ASGW) developed several core competencies for group leaders that include: knowledge of group leader approaches and styles, group work methods, and principles of group process (1990). The group leader in psycho-education groups must be competent in two domains: (1) general skills and competencies associated with psycho-educational group format and (2) mastery of content associated with specific topics selected for the group. Nurses have knowledge in a wide variety of areas due to their education and training. Nurses can share their knowledge and experiences with group participants by using the psycho-educational group format.

The group leader for psycho-educational groups plays an active role in the group process. He or she provides direction as the group members interact and determine topics or activities with a specific goal in mind. With groups that are prone to frequent turnover, independent or session-contained topics should be chosen. The goal of using a pre-

determined, structured curriculum for these groups is provide participants with knowledge, skills and strategies that can be easily used and implemented.

The effective psycho-education group leader possesses certain leadership characteristics as identified in Brown (2011, pp 80-81). These characteristics are detailed here.

Belief in the Group Process: Participants are reassured that they will be accepted and respected by fellow members and believe participation in the PE group will benefit them. The group leader assures an atmosphere of safety for group members by: (1) pre-planning work prior to each session, (2) handling members' spoken and unspoken questions effectively, (3) containing and managing the leader's own personal anxiety, and (4) being flexible during the group session.

Self-confidence: By the group leader's example or modeling, group members are taught self-confidence. This happens over time through positive experiences during the group. The quality of one's experiences within the group affects the member's acceptance of his or her abilities when he or she leaves the group setting.

Courage to risk: The psycho-education group leader must be willing to expose oneself to possible failure or criticism. This enables group participants to experience firsthand consequences of failure or criticism within the group and to observe how this can be handled by the leader.

Ability to admit mistakes: An effective group leader models an acceptance of self and conveys an attitude of acceptance of others within the group. This helps group members believe that the group leader will accept them and not expect them to be perfect.

Being organized: In order to be an effective group leader, one must do considerable work before the group session begins to ensure that participants will attain whatever goals the leader has set for the group. The initial preparation, including handouts and use of the blackboard or dry erase board, promotes participation by group members throughout the session. It gives members something to focus on thereby reducing anxiety and enhancing learning. The toolkit contains handouts, sample topics for the PE group leader to consider in

the pre-planning phase. A more structured format is often desirable to ensure greater participation by group members.

Flexibility: As the group leader facilitates discussion on the chosen topic, he or she needs to avoid being rigid. However, the leader must also be able to bring group members back to the chosen topic if they stray too far from the topic being discussed. This takes some experience on the leader's part. It can be done by redirecting the conversation to "what is being discussed today." The leader's ability to look at a changing situation within the group and make appropriate adjustments can enhance the progress of group discussion. To be effective, the PE group leader must balance being inflexible and adhering to the chosen topic with being too flexible and allowing aimless discussion.

Tolerance for ambiguity: Although staff nurses know Veterans well, psycho-education group leaders may not always know the educational levels, abilities, emotional concerns, and physical conditions of group members. This is often due to the high turnover inherent in many group settings. Feeling comfortable and confident within the group setting helps the group leader set the tone for the group. Group members will pick up in the leader's cues and members' anxiety levels then can lessen as the group commences.

Self-awareness: Any psycho-education group leader must monitor their own emotional balance and be aware of his or her responses within the group discussion. Countertransference issues arise even in PE groups. Thus, the PE group leader needs to be aware of personal issues, recognize countertransference when it appears, and understand its impact individually and on the group as whole. Respect for individual members and their contributions, and tolerating different points of view expressed within the group will assure that group members feel that their input is valued.

An appropriate sense of humor: One of the most important prerequisites for an effective group leader is the ability to see humor in things and be able to laugh at oneself and at one's mistakes. Seeing the humor in something reduces tension, promotes a sense of playfulness among members, and contributes to a general sense of well-being among group members.

The psycho-education group leader's basic leadership characteristics as listed also involves his or her (1) **ability to care**, (2) **show warmth toward others**, (3) **possess unconditional positive regard** (Yalom, 2005) and (4) **be genuine with others** are all extremely important. Caring can be shown in the way the leader attends, listens, and directly responds to what is being said within the group. As the leader interacts with participants, exhibiting positive personal regard shows the worth and uniqueness of each group member. The leader's facial expression should also demonstrate warmth. Leaders show positive regard by listening and being willing to hear members' perspectives without judging them or reacting strongly.

Self-Assessment of Leadership Characteristics

Personal Leadership Characteristics	Yes	No	Needs Work
✓ Belief in the group process			
✓ Self-confidence			
✓ Courage to risk			
✓ Ability to make mistakes			
✓ Being organized			
✓ Flexibility			
✓ Tolerance of ambiguity			
✓ Self-awareness			
✓ Appropriate use of humor			
✓ Ability to care			
✓ Show warmth toward others			
✓ Possess unconditional positive regard			
✓ Be genuine with others			

Yalom (2005) and Brown (2011)

Faulty Leadership Strategies

Three counterproductive techniques that new group leaders sometimes use are:

1. Attempting to overcome resistance
2. Asking questions to further discussion
3. Problem-solving by advice giving

Resistance is a natural defense to any material, situation, or interaction that a group member may find threatening. It is a pushing away from change. Resistance does not have to be eradicated or challenged by the group leader. Extensively answering questions may provide more information, but may also divert members from following the identified focus. The leader may ask questions to take control of the direction of the interaction when interacting with the individual member if this direction of questions will promote growth. Finally, group leaders and members may be tempted to respond to their "righting reflex" and give advice or problem solve. This is not to be confused with educating or providing information after obtaining the group member's permission. The three above counterproductive techniques can cause problems for the novice group leader and can actually serve to increase the group member's resistance (Cole, 2008).

Therapeutic Communication Skills

In addition to group leadership characteristics, specific therapeutic communication skills that the psycho-educational group leader uses are needed. Often these skills are learned during the basic nursing education curriculum.

Attending skills: Nonverbal behaviors show group participants that the group leader is listening to what each group member is saying. You can demonstrate attending skills by leaning forward slightly as you listen to what is being said, maintaining eye contact with the speaker, orienting your body towards the speaker, and not becoming distracted from what the speaker is saying.

Reflection: Stating back what is heard to the group members will allow the speaker to clarify any misunderstanding and elaborate further if necessary.

Summarization: Concisely stating the key elements discussed during the group session helps members come away with the key points the group leader wants to emphasize: a "take home message" for members to remember and begin to implement.

Active listening and responding: This acknowledgement of what is being said demonstrates the caring and respect the group leader has for participants and what they are contributing to the group as a whole.

Clarifying: Reflecting back your understanding of what is being said as well as actively listening helps the leader keep the group discussion on track and helps members better retain what they are hearing.

Supporting: Validating and clarifying individual input into the group discussion provides encouragement and affirmation to the member as well as modeling supporting behaviors to group participants.

Self-Assessment of Therapeutic Communication Skills

Therapeutic Communication Skill	Yes	No	Needs Work
✓ Attending Skills			
✓ Reflection			
✓ Summarization			
✓ Active listening and responding			
✓ Clarifying			
✓ Supporting			

✓	Knowledge Check
	I know the two types of leadership functions within group work: task and maintenance.
	I know that material presented is likely to be retained if: -It is meaningful -There are no distractions to the learning process -It can be applied to real-life situations -Homework opportunities are offered -There is psychological and physical readiness on the learner's part
	I know the thirteen characteristics of effective leadership and have completed a personal self-assessment of these characteristics.
	I know the three counterproductive techniques that new group leaders may use.
	I know six areas therapeutic communication: attending, reflection, summarization, active listening and responding, clarifying, and supporting.
	I have completed a personal self-assessment of my therapeutic communication skills.

Module 4: Anticipating Challenges and Conflict

Objectives:

You will be able to:

1. Identify five types of challenging behaviors and strategies to deal with them
2. Describe five responses to conflict
3. Review the fundamentals of confrontation

Key Concepts

Leaders are challenged by member behaviors that distract the group from its goal

Conflict is a natural occurrence in diverse groups

Confrontation is a management tool that can be used constructively

Challenging behaviors in groups can be classified as over-participation or under-participation. Over-participation includes monopolizing, attention-seeking and leader's assistant; while under-participation includes nonparticipation and socializing. Each of these challenges is described with suggested leader strategies.

Over-participation

- **Storytelling and monopolizing**: Within a group, there is the potential for a member to attempt to monopolize the group with extensive comments, stories or questions.

  Strategy: It is important for the group leader to respond to this behavior in a respectful way that does not criticize or diminish the value of the member's contribution. The group leader may allow the first instance to occur without intervention or attempt to connect the subject of the comments or stories to the subject or goals of the group. Subsequently, other group members may be called upon before the dominating individual. The member may be gently interrupted with a time reminder or redirection. Other group members may also limit the individual's input.

- **Attention Seeking**: In a group composed of adults, physically distracting behavior is less common than in a children's group, unless the Veteran has some dyskinesia or other

symptom that causes repetitive tics or continuous motion. Attention seeking behavior needs to be differentiated from abnormal movements.

Strategy: Establish clear guidelines for group behavior at the beginning of each group. Attention-seeking behavior can be handled by ignoring or addressing the behavior, depending on the circumstance. Address the behavior by pointing out that it is difficult to focus while the behavior is occurring. Ignoring the behavior may decrease it by cutting off attention. Either may serve to increase or decrease the attention-seeking. The group leader must decide which will be the most effective response.

- **Leader's assistant:** One or more group members begins to act like the leader. This may be a desire to replace the leader, assert dominance or to demonstrate superiority.

  Strategy: Determine whether the person is trying to be helpful or if there are other reasons for the behavior. One or more conflict management responses may be helpful.

Under-participation

- **Non-participation**: Group members may sometimes choose not to participate in group, either due to resistance to the group itself, fear of vulnerability or resistance to authority. This is especially true if the group is mandatory or if other privileges depend on the member's presence in the group. Participation cannot be coerced.

  Strategy: It is sometimes beneficial to address the level of participation in the group itself, acknowledging that the desire to participate varies with individuals. This acknowledgement will sometimes increase members' willingness to contribute to the group. When a member fears vulnerability in regard to participating in the group, it is best to allow the member to choose whether and how often to contribute, assessing his or her own comfort level and feelings of trust and safety. The self-protective member can be asked from time to time if he has any comment, and any comments he does make can be affirmed positively or reflected neutrally to reinforce the contribution. Decreased participation may also arise through forms of hostility. In this situation, the group leader may not attempt to engage the member in the group, but may find it necessary to block abusive or inappropriate behavior, acknowledging the member's desire not to be present in the group.

- **Socializing**: Socializing is a form of under-participation. The group member who socializes excessively, talking, laughing and interacting with other members is disengaged from the group focus. The socializing member will require redirection.

  Strategy: The group leader may move closer to the socializer, speak to them privately outside of group, or may call on them directly within the group.

Experienced group leaders will develop the skills necessary to deal with problem behaviors. They should be familiar and comfortable with techniques such as directing, providing structure, motivating, affirming, eliciting response and empowering group members. Continual training and clinical supervision facilitate the acquisition and use of these skills.

Potential for conflict

There is the possibility for conflict within any group and may occur member to member, individual member to group leader, or multiple members to the group leader. Conflict may originate from the diversity of group members (age, gender, race, education, religion, lifestyle, disability), from sincere differences of opinion, from general hostility, or from animosity and resentment of authority figures.

The skilled group leader will be prepared to deal with conflict. Conflict does not always need to be suppressed or diverted within the group, it may be an opportunity to build relationships and learn new skills such as constructive conflict resolution or how to confront and cope with conflict without fear.

Five responses to conflict within the group with examples

- **Holding firm response:** Clear, firm direction is given

  "I am going to break into the discussion here and remind members of the agreement we all made to maintain respect for differing points of view. We can continue to discuss this point if you like. However, all group members must take part in the discussion and respect for one another must be demonstrated. Or I can address the point in question and make a decision. Which do you prefer?"

- **Distracting response:** Conflicts are managed by ignoring, distracting or delaying

"I wonder if you two can hold off present your points of view until the group deals with _____? I promise that we will get back to them."

- **Soothing response:** may serve to reduce tension until the conflict may be genuinely worked out, but does not necessarily result in a workable solution.

  "I can see that both of you feel strongly about this issue. It would be helpful if each of you would help me and the other members understand your point and its importance to you. If you agree, you can present your viewpoint one at a time. We'll go in alphabetical order by last name."

- **Compromising response:** involves an exchange of sorts; both parties give a little in order to reach agreement. Both need to be willing to find a solution in order for compromise to work.

  "There are a lot of questions and much material to review. How about you jot questions and we will allow enough time to review them at the end?"

- **Confronting response:** offers to the other person the opportunity to explore the effects of his or her behavior on the leader or on the group.

  "Your argument is affecting group members, and I can see that they are uncomfortable. I feel somewhat uncomfortable as well because you both seem ready to have a fight. I wonder if it's possible to discuss the disputed point with you."

(Brown, 2011, p. 180)

The Types of Confrontation

Confrontation, one of the five most common approaches to conflict management, is not necessarily the negative process that we often assume it is. It can be used constructively to encourage group members to increase their awareness of the effect of their behavior and how it is perceived. There are various types of confrontation:

- **Didactic:** assumes the receiver lacks information and the remedy involves more than just giving important missing information and reviewing its impact

- **Experiential:** sharing how the individual experiences the member and how this is different from the member's perception of himself
- **Weakness:** focusing on the member's shortcomings and how they affect their relationships, such as asking the member to describe how their chronic lateness impacts others
- **Strength:** asking the member to examine available resources
- **Encouragement to action:** supporting the member in choosing a response

Didactic and identification of weakness have been found to be the least effective types of confrontation. Encouragement to action and strength are the types of feedback most positively received (Brown, 2011).

Prior to confronting a member, the group leader needs to take into account the purpose of the group, the level of trust established in the group, the nature of the conflict, members' psychological state, members' willingness to change, the leader's own motives, and the rationale for confronting. The purpose of confrontation is not to attack; it is an invitation to increase self-awareness and understanding of the member's effect on others. Confrontation may be a difficulty skill for the new group facilitator.

Fundamentals of Confronting

Successful conflict resolution is based on simple, common-sense ideas that are often difficult or uncomfortable to actualize. It is beneficial for the nurse to engage in reflective self-assessment of fundamental strategies that result in successful conflict resolution. The following table is adapted from Brown (2011, page 185) and may be used as a guide to determine skills in which a nurse may need assistance. It can be helpful to recall a difficult conversation about an issue that needed to be resolved without hurting or upsetting another person. Brown (2011) suggests brainstorming, practicing, and role-playing the process of conflict resolution. Bearing in mind a role-play, practice, or difficult conversation with another person rate how confident you are using the fundamental skill listed in the left column:

FUNDAMENTAL	VERY CONFIDENT	MODERATELY CONFIDENT	NOT CONFIDENT NEED MENTORING
Use a positive approach			
Choose words that suit the receiver's emotional state			
Be concrete; say what is on your mind			
Be aware of the impact you are having on the receiver			
Wait for a response or reaction			
Be sure of your facts			
Do not exaggerate or make broad generalizations			
Think before you speak			
Check to ensure that you are being understood accurately			
Stick to the topic; do not bring in other concerns or issues			
Try to not criticize			
Do not impose your views; just express them			
Be receptive to feedback			
Listen to the other person			
Do not interrupt			
Give people the time they need to absorb the information			

✓	**Knowledge Check**
	I can give examples of four challenging behaviors and leadership strategies
	I know five responses to conflict
	I can discuss the various types of confrontation
	I can identify at least five fundamentals of confrontation and know how to become proficient at using these fundamentals

Module 5: Implementation, Group Techniques, and Evaluation

Objectives:

You will be able to:

1. Delineate and operationalize group implementation strategies
2. Identify the most common techniques utilized to facilitate psycho-educational groups
3. Apply appropriate technique use with a variety of settings and audiences
4. Distinguish modes of evaluation

Key Concepts
Nurses should follow effective steps in implementing groups
Many teaching techniques enhance the effectiveness of the group
Practical suggestions can facilitate smooth and functional group processes
Evaluating a group is critical for the effectiveness of a group
Knowing how to evaluate a group is an important professional development skill for nurses

Previous modules of this guide have provided an overview of the historical context, evidence base, concepts, structure, and topics related to forming and facilitating PE groups. Psycho-educational groups are the most common type of groups conducted by nurses in a variety of settings, such as inpatient, outpatient, residential and in community settings (Fortinash & Holoday Worrett, 2008). Literature shows that PE groups are very effective for improving treatment adherence. Patients find groups regarding diagnoses and medication education to be most useful (Keltner, Schweke, & Bostrom, 2007). PE groups are intended to teach specific tasks, skills, or knowledge to Veterans. (Van Servellen, Poster, Ryan & Allen, 1991).

Implementation of Groups

To implement a PE group, the nurse must plan ahead and be prepared. Information must be gathered, group structure must be determined, and final preparations must be made to present a 'finished product' to attending group members.

The following group implementation steps include (Brown, 2011; Garvin, Gutierrez & Galinsky, 2006; Townsend, 2006):

- **Define the primary content of group:** Determine the focus of the group topic in relation to the needs of the cohort of patients selected: i.e. diagnosis/medication education, coping skills role play, anger management, etc.
- **Complete a literature search of the topic:** The VA Library has over 1,000 online books and over 600 full text journals available for gathering source information at no cost to VA staff. Nurses not familiar with performing literature searches should seek mentorship from peers experienced in literature searches or with library staff who are generally quite willing to provide such training. The Internet is a source of ideas for groups and helpful worksheets. Nursing education and outpatient staff within individual facilities may have access to additional resources or have ideas about groups.
- **Identify instructional strategies and materials needed to complete the group:** This may need to be tailored to the milieu. Strategies may include nurse led didactic lecture (passive learning which may be less effective), nurse facilitated discussion, or nurse monitored patient led group. Materials may include videos, power points, therapeutic games, instructional handouts, simulations, role-play scripts, etc.
- **Bring the necessary tools to conduct the group:** This includes writing utensils for members and group leader, worksheets, homework, etc. Provide a method for taking attendance and recording individual contributions to the group activity, for use in documentation.
- **Choose the group cohort:** Members may be chosen for their interest in or relevance to the subject, or may be based on patient level of functioning. Further membership selection may be made by diagnosis, identified need, or Veterans' specific conflict (i.e. OIF/OEF, Viet Nam, WWII). After careful discussion with the Veteran's treatment team; consider excluding patients who are too unstable for a group process, for whom the information would be irrelevant, or for those who may not be able to absorb the information (i.e. a confused or dementia patient may not do well in an interactive, dynamic medication group or other PE groups).

- **Define the group size:** Four to twelve members are usually recommended for a single facilitator to provide individual attention however, PE groups may be larger. If a larger sized group is offered, the leader should recognize that less time is available for individual interaction. In larger groups, those members who are more assertive are most likely to be heard however, there is also more opportunity to learn from others (Townsend, 2006).
- **Consider the group type**: In an open group, members can join and/or leave at any time while the group structure is in existence (does not imply that members can come and go during a group session). Groups should be independent of one another. As a result, new members can come for each session, without feeling like they have missed out or feeling like they are intruding on an already established group dynamic. A closed group has a predetermined, fixed time frame and set number of sessions - such as an eight session tobacco cessation program (Townsend, 2006).
- **Construct a framework for sessions:** Decide the duration of groups (suggest 45-60 minutes). If conducting a closed group, determine the number of sessions to be held. Conduct a brief "check in" with members to ascertain their rationale and goals for attending the group. When finishing a group, conduct a brief "check out" with members to determine if goals were met and if further follow-up is needed.
- **Post a group schedule for advance notice to the patients:** This notice can also help make the group a priority for staff (increases accountability). The patients will have the opportunity to develop interest and look forward to the groups that are available to them.
- **Wisely choose the location & setting:** This placement should be conducive to learning, convenient for staff and patients, have adequate temperature and lighting, and have limited distractions such as others walking through the room, overhead pages, etc. Overall, the group environment should be in a setting where participants can learn from each other
- **Challenge your expectations:** During preparation, the group leader should challenge their professional expectations: Do you believe in the information you are offering? If so, the group will be more believable and patients will likely be more engaged in the process.

- **Define measurable goals:** Establish 1-2 goals and 1-2 objectives for each defined topic and established group session (these can be written up as a template for group documentation in the patient's chart). Use S.M.A.R.T. as a guideline to define the goals/objectives (Marsland, E. & Bowman, J., 2010)
    - **S**pecific
    - **M**easurable
    - **A**ttainable
    - **R**eview
    - **T**imely
- **Establish short and simple evaluation criteria:** Determine the patient perception on the use and worth of the group, or assesses patient satisfaction using a measurement tool (i.e. Likert Scale).
- **Write a lecture/group guide:** Prioritize, organize, and sequence information (Brown, 2011); create shared templates for co-leaders or for professional back-up staff; consider creating a VA SHARE point (repository of information and resources for the group).
- **Conduct pre-group screening for members:** the treatment team should assess the Veteran's current mental and emotional status to determine stability for group participation.
- **Consider doing a pilot study:** explore doing a first session for feedback.

Teaching Techniques

Psycho-educational groups utilize a variety of teaching techniques. The most common techniques are lectures, discussions, exercises, games, role-playing, simulations, and media. Active participation in group keeps member attention for a longer period of time than passive learning. This adds retention of information and better learning of the material. The leader must have the ability to help members deal with any potential emotions and must plan sessions so that there is a minimal likelihood of arousal of intense, uncomfortable feelings. Factors in

choosing teaching techniques are leader preference, current format of any evidence-based material, and the type and characteristics of group members. Teaching techniques include:

- **Lecture:** a well-organized presentation helps listeners understand and apply material to their day-to-day life. A lecture is most effective when limited to 10-20 minutes duration. It is an efficient means of delivering a lot of information in a short period of time. The drawbacks include short attention spans of listeners, loss of interest and passive learning is less effective than active learning. An example of a lecture is telling a member the side effects of a particular medication.
- **Focused discussion:** The group leader asks questions of members, calls for comments or questions, and explores points, issues or concepts with group members. This is a good technique for smaller groups or for brief periods in larger groups. This technique encourages active participation and can help members feel that their input is valued. An example of a focused discussion is asking if the group has any questions about a presented concept.
- **Exercises:** planned activities help patients put skills into practice and help promote self-reflection, self-awareness, self-knowledge, and/or self-understanding. An example of an exercise is asking members to make a list of what they want on the left side of a sheet of paper and list what they need on the right side of the paper.
- **Games:** help members put skills and concepts into practice in a fun way. They can also be used as icebreakers and tension-relievers. An example of an icebreaker game is having each member identify one strength that he or she has.
- **Role-play:** Members recreate a situation where they can see first-hand where certain statements or actions can lead to certain reactions or consequences from others. Role-play can recreate a situation which is difficult for a given member and allow them to obtain a better understanding of contributing behaviors. It is important for the group leader to assist observers and participants in processing the role-play afterwards as they may experience intense feelings. An example of a role-play is asking a member to re-enact how he tells his wife he feels hurt by a particular behavior she does/doesn't do towards him.

- **Simulations:** Members practice new skills and behaviors in a safe environment. The focus is on developing solutions to a problem. It is also important here for the group leader to assist observers and participants in processing the simulation afterwards. An example of a simulation is asking a member to act out a scene of talking to his wife using a new skill such as "what I hear you saying is" when she makes a statement about what she wants him to do differently.
- **Media:** Communication tools such as movies, audiotapes, videotapes, computer presentations, DVDs, posters and handouts can be used as teaching aids. Media can be useful in covering a large amount of material in a short time. They hold interest easily and can assist members in understanding and retention of group material. An example of the use of media is giving patients a handout on the side effects of antipsychotics.

Practical Suggestions for Facilitating Groups:

Here are some practical suggestions to facilitate a smooth and effective group:

- Provide good eye contact and reinforce participation.
- Start group sessions by having all members introduce themselves if the members have not met or interacted previously. A quick 'ice-breaker' ("my favorite sports team is…") helps to set a friendly tone to the group.
- Set ground rules establishing appropriate levels of confidentiality; members are to demonstrate respect for their peers and not bring up information outside of group, unless they have each other's permission. If members wish to provide feedback to peers, it is best to use "I" statements. All of these suggestions help to build trust within the group unit.
- Review the purpose of the group. Give handouts or group information, during the initial discussion, at the implementation of the group program. Encourage participation, but allow members the ability to quietly observe (this may be acceptable passive participation). "Warm-up activities encourage clients to share feelings, thoughts, and experiences, while opening the way for clients to present their issues, connect with others, and develop trust" (Keats and Sabharwal, 2008, p. 307).

- Move the discussion forward by calling on members by name to offer their input, by validating member comments or discussion, by keeping the discussion general, and by setting limits with members who monopolize the conversation with numerous personal stories. Members having difficulty sharing the group process equally, can be provided a menu of options to be heard inside or outside of the context of the group.
- If the topic becomes difficult, acknowledge the feeling and discuss it openly. Provide a safe environment to discuss difficult subjects. It is important to identify feelings in order to empower participants to gain the skills needed to facilitate behavior and thought changes. If an argument or conflict arises, address the situation tactfully and firmly. It is best to identify rules of etiquette and behavior expectations at the onset of group, rather than waiting until a difficult time is present. Encourage 'give and take' discussions with the emphasis on learning from each other and building tolerance for others with different points of view. Use conflict as a teachable moment to demonstrate and role model successful conflict resolution skills.
- The group leader has the responsibility to keep the group milieu safe and non-threatening. If there are members who are disruptive, violent, or hostile towards peers, the group leader must take measures to correct the negative behavior. If disruptive behavior continues, the patient may be asked to leave the group or be physically removed from group. It is important for experienced group leaders to mentor novice group leaders in this skill.
- At the conclusion of the group time, it is helpful to review information, provide a debriefing ("What are the 'take home points' from this session?"), assign homework, offer further information, and close the discussion. Time must be reserved for comments or concerns from group members. This provides closure for the group members and refocuses attention to the individuals' personal thoughts about the group process and topic.

Evaluation of a Group

Evaluation of a group is essential to provide nurses with information to improve care, programs and outcomes. It is important for the nurse to objectively evaluate each dimension of care, including the group process. The therapeutic nurse/client relationship is central in

providing effective psychiatric nursing care, while interventions such as conducting groups remains a key element. The group leader carefully and objectively evaluates each aspect of the group including content, process, group dynamics and the responses from both the client and nurse. Psychiatric nurses have a responsibility to ensure they are maintaining a therapeutic relationship at all times with clients, while remaining continuously objective in evaluating the nurse-client relationship, as well as responses from the client within the group. The nurse objectively reflects, interprets, and evaluates these responses. This evaluation is documented into the legal patient record in CPRS (see Toolkit).

As part of the evaluation process, nurses also have a responsibility to evaluate their own nursing practice by introspectively examining their own feelings and responses to clients, as well as their ability to effectively lead a group. Through this self-evaluation process, it is possible for nurses to develop insight and enhance their own learning and development. Evaluation conducted with an experienced group leader mentor is vitally important and is recommended.

✓	**Knowledge Check**
	I know and understand steps in effectively implementing a group begins with defining the primary content of the group that includes a thorough literature search of the chosen topic
	I know that implementing a group includes setting measureable goals and contains an evaluation to obtain patient feedback
	I know there are useful teaching techniques including: -Lecture -Focused discussion -Exercises -Games -Role-play -Simulations -Media
	I know several practical suggestions that can help a group run smoothly and effectively
	I know evaluating a group is a critical step in improving psycho-educational groups
	I know that the skill of accurately evaluating a group is an important step in my professional development

Tool Kit for Developing a Psycho-educational Group

Planning

A. Staff Nurse Planning Worksheet for Development of a Psycho-education Group

B. Sample Group Handout Template

General Group Examples

C. Coping with Symptoms, including patient workbook (C.1.)

D. Basic Medication Education

E. Writing for Recovery

F. Recovery in Action

G. Pain Management

Motivational Interviewing Description and Group example

H. Motivational Interviewing introduction

I. Medication Education Motivational Interviewing style

Evaluation and Documentation

J. Staff Evaluation Tool for Psycho-educational Groups

K. Sample template for a CPRS group note

Websites and Resources

Tool Kit A: Staff Nurse Planning Worksheet for a Psycho-education Group

Name of group/activity: _____

Staff primarily responsible: _____

Type of group/activity: Psycho-educational (*teaching health and mental health information for effective living/problem management and recovery*)

Treatment Objective(s): the patient will be able to:

Overall, what is the patient expected to accomplish as a result of attending/participating in this program? **(Hint: one treatment outcome is enough)**

_____

_____

Group/activity objective(s): the patient will be able to:

What is the patient expected to accomplish/learn/gain each time he/she attends/participates in this group/activity? **(Hint: Refrain from writing more than three objectives)**

1. _____
2. _____
3. _____

Procedure(s): What happens – what procedure(s) are used – in conducting this group/activity? **(Hint: Education, discussion, role-playing, scenarios, written assignments, and demonstration is the primary modalities)**

1. _____
2. _____
3. _____

Topic(s): What is being presented in the group/activity?

1. _____
2. _____
3. _____

Resources used for the group(s):

Tool Kit B: Sample Group Handout Template

Staff responsible:

Type of group/activity: *Psycho-educational*

Schedule: (time and day)

Program Objective: As a result of attending and participating in this program, you will be able to:

Group/Activity Objective(s): During group you will be able to:

1.

2.

Group Process:	**Topics:**
Orientation Working Termination	

Tool Kit C: Example of Coping with Symptoms Group

Classes, Groups & Activities

Coping with Symptoms Group

Staff responsible: Nursing

Type of group/activity: Psychoeducational *teaching medical/mental health information for effective living/problem management*

Schedule: 9:30 – 10:30 AM

Monday through Friday

Program Objective: As a result of attending and participating in this program, you will be able to:

List diagnosis, current symptoms and warning signs of relapse

Write a comprehensive symptom management plan

Group/Activity Objective(s): During meetings you will be able to identify:

persistent personal symptoms

appropriate strategies to address persistent personal symptoms

personal warning signs of relapse

appropriate responses to warning signs of relapse

Group Process:	Sample Topics:
Introduction of patients and staff Education on symptoms of mental illness Education and group discussion on managing symptoms using effective coping skills In-class worksheet exercises that apply coping skills taught Homework assignments	Introduction to symptom management Coping with anxiety disorders Coping with mood disorders: bipolar affective disorder depression Coping with schizophrenia Coping with persistent mental health symptoms

Tool Kit C.1.: Sample Patient Workbook for Coping with Symptoms Group

Coping with Symptoms Workbook

Welcome to the ***Coping with Symptoms Workbook.***

Definitions

Coping: What you can do to manage your symptoms.
Symptoms: What you experience

Workbook Goals:

1. To help you recognize your symptoms, and
2. To make a plan for dealing with your symptoms in a personalized way

Your Mental Health Diagnosis/Diagnoses

A diagnosis is a medical name for a group (or pattern) of symptoms for a mental illness.

Diagnoses are not intended to "label" and do not describe the whole person.

What is your mental health diagnosis?

_____

_____

_____

What is Your Understanding of Your Mental Health Diagnosis?

Staff can help explain your diagnosis to you. Write what you understand below:

_____

_____

_____

What are Your Most Troublesome Symptoms? *Please list below:*

_____

_____

_____

_____

Which Symptoms Do You Feel You Can Change? *Please list below.*

_____

_____

_____

What Support Will You Need for Your Management Plan?

List the support (people, places and things) that you will need to be successful with your management plan.

_____

_____

_____

My Management Plan: List at least **three** of your current psychiatric symptoms and write a complete plan for managing each.

1. Symptom_____

Management Plan:

_____

_____

_____

2. Symptom_____

Management Plan:

_____

_____

_____

3. Symptom_____

Management Plan:

_____

_____

_____

Tool Kit D: Basic Medication Education Group

Classes, Groups & Activities

Medication Education Group

Staff responsible: Nursing

Type of group/activity: Psychoeducational *teaching medical/mental health information for effective living/problem management*

Schedule **8:30 – 9:15 AM**

Tuesdays and Thursdays

Program Objective: As a result of attending and participating in this program, you will be able to state two reasons and actions necessary to comply with taking prescribed psychiatric medications.

Group/Activity Objective(s): **During meetings** you will:

1. List four major types of psychiatric medications
2. State symptoms **antispychotic** drugs are used to treat, and list three common side effects
3. State symptoms **antimanic** drugs are used to treat, and list three common side effects
4. State symptoms **antidepressant** drugs are used to treat, and list three common side effects
5. State symptoms **antianxiety** drugs are used to treat, and list three common side effects
6. List your prescribed medications, schedule/dosage and the symptoms these drugs are treating
7. Identify at least five strategies to manage any side effects you may experience
8. State when it is important to notify his/her doctor/clinic with a medication concern

Group Process:	Sample Topics:
• Introduction of patients and staff • Define major types of drugs used to treat mental health problems • Review 4 drug classes: antipsychotics, antimanics, antidepressants, antianxiety • Completion of Medication Workbook	• Antipsychotic medications • Mood disorder medications: Antimanic / antidepressants • Antianxiety medications

Tool Kit E: Example of Writing for Mental Health Recovery

Classes, Groups & Activities

Personal Writing for Mental Health Recovery

Staff responsible: **Nursing**

Type of group/activity: *Psychoeducational Teaching mental health recovery for effective living/problem management*

Schedule: **8:00 – 8:45 AM**

Mondays and Fridays

Program Objective: As a result of attending and participating in this program, you will be able to: develop a plan for your mental health recovery.

Group/Activity Objective(s): **During meetings** you will be able to:

1. Define mental health recovery.
2. Identify the 10 Fundamental Components of Recovery.
3. Develop a Strengths, Needs, Abilities, Preferences (SNAP) Assessment and Plan for Recovery.

Group Process:	Topics:
• Introduction of staff and patients • Interactive exercises • Facilitated group discussion • Lecture • Patient assignments in ***Veteran's Resource Book.***	• What is mental health recovery? • Becoming my own advocate • 10 Components of Recovery • Working with my strengths, needs, abilities, preferences in recovery plan development

Tool Kit F: Example of Recovery in Action Group

Classes, Groups & Activities

Recovery in Action

Staff responsible: Nursing

Type of group/activity: *Psychoeducational Teaching mental health recovery for effective living/problem management*

Schedule: **11:00 – 11:45 AM**

Saturdays

Program Objective: As a result of attending and participating in this program, you will be able to: interact with peers in the mangement of problematic situations that may influence your mental health recovery.

Group/Activity Objective(s): **During meetings** you will be able to:

1. Learn about mental health recovery.
2. Discuss the importance of mental health recovery in your daily life.
3. Role play and practice new communication skills.
4. Provide appropriate and positive feedback to peers.

Group Process:	Topics:
• Introduction of staff and patients • Interactive exercises • Facilitated group discussion • Patient assignments in ***Veteran's Resource Book.***	• Various situations or scenarios describing issues in mental health recovery • Problem solving techniques • Communicating effectively • Giving positive feedback to others.

Tool Kit G: Example of Pain Management Group

Classes, Groups & Activities

Pain Management Group

Staff responsible: Nursing

Type of group/activity: Psychoeducational
teaching medical/mental health information for effective living/problem management

Schedule 8:30 – 9:15 PM Thursdays

Program Objective: As a result of attending and participating in this program, you will be able to complete a pain log and identify one specific action that you can take to help manage your pain.

Group/Activity Objective(s): During meetings you will be able to:

1. Know the difference between acute and chronic pain
2. Complete a pain log
3. Discuss non-medication pain alternatives to incorporate into a pain management plan

Group Process:	Topics:
• Introduction of staff and patients • Define pain • Teach/educate pain topics • Discuss the variation in pain responses • Questions & Answers • Patient workbook sheets	• Types of pain • The pain scale • Non-medication pain management strategies • Pain medication education • Pain medication and addiction • Medications and Tolerance: Do I have tolerance or poor pain control? • How do I know when the medications are not working? • Depression and Pain interralationship • Medications are not the only treatment for pain • Goal of pain management is to improve function not stop all pain • Psuedo-addiction and poorly managed pain • Opioid Safety initiative • Medication combinations can be deadly (Opioids and Benzodiazapines) • Taking pain medication as prescribed and not escalating dose without speaking to your provider • Taking more medications than prescribed can be hazardous to your health (Naproxen can cause GI bleed) • Antidepressants can help relieve nerve pain and help with sleep (amitriptaline, nortriptyline, duloxitine) • Sleep hygiene is important for patients with chronic pain

Chronic Pain Management Workbook

This workbook is designed to help you better understand your chronic pain and how to manage it effectively. By logging your pain and observing your pain-related behavior, you may learn that there are specific actions that you can take to help control your pain.

Date:_____ Time:_____ AM/PM

How would you rate your pain?
Indicate your current level of pain by marking (X) on the scale below:

Least severe 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 *Most severe*

Describe your pain and any factors that increased your pain in the last ½ hour:

_____

_____

_____

Date:_____ Time:_____ AM/PM

How would you rate your pain?
Indicate your current level of pain by marking (X) on the scale below:

Least severe 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 *Most severe*

Describe your pain and any factors that increased your pain in the last ½ hour:

_____

_____

_____

Date:_____ Time:_____ AM/PM

How would you rate your pain?
Indicate your current level of pain by marking (X) on the scale below:

Least severe 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 *Most severe*

Describe your pain and any factors that increased your pain in the last ½ hour:

_____

_____

_____

Date:_____ Time:_____ AM/PM

How would you rate your pain?
Indicate your current level of pain by marking (X) on the scale below:

Least severe 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 *Most severe*

Describe your pain and any factors that increased your pain in the last ½ hour:

_____

_____

_____

Date:_____ Time:_____ AM/PM

How would you rate your pain?
Indicate your current level of pain by marking (X) on the scale below:

Least severe 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 *Most severe*

Describe your pain and any factors that increased your pain in the last ½ hour:

_____

_____

_____

Pain Management Group Workbook

After completing the pain log on the previous pages, list at least two specific actions other than pain medications that you can take to help manage your pain.

1. _____

_____

_____

_____

_____

_____

_____

2. _____

_____

_____

_____

_____

_____

_____

Tool Kit H: Motivational Interviewing Introduction

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is an extremely useful skill for registered nurses and can enhance therapeutic interactions with patients. It is defined as, "Motivational Interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller and Rollnick, 2013, p.12.). It would be misleading to project an image that MI is a skill that one could simply read about or attend a short in-service and come away with expertise in MI. Skillful use of MI is an acquired ability that includes reading and practicing activities with others who are learning and with persons who have expertise in teaching MI. This often occurs over several training sessions and follow-up with an evaluation process called Motivational Interviewing Treatment Integrity (MITI). Miller and Rollnick (2013), the founders of MI, endorse both fidelity to the MI model plus creative adaptations to clinical situations. Thus, MI is not a stand-alone treatment, but a style of facilitating group and individual interactions as applied to any number of topics and behavior change initiatives. For nurses looking to gain experience and abilities with using MI, it is suggested that they seek out further information and training through the following resource and citations noted in the Toolkit section of this document:

Motivational Interviewing (training, information, resources):
http://www.motivationalinterview.org/

STAGES OF CHANGE (SOC)/TRANSTHEORETICAL MODEL (TTM)

The Transtheoretical Model is often referred to as the Stages of Change (SOC) and was developed by Prochaska & DiClemente (1984). This model helps to explain human behavior and how change can occur. It is very useful to nurses, who can use the theoretical underpinnings to move from the realm of nursing knowledge into the realm of nursing practice. Understanding the SOC can help nurses develop tasks in order to facilitate and support patient intentional change. The five stages are: Precontemplation, Contemplation, Preparation, Action, and Maintenance. During the Precontemplation stage patients are not considering change ("Ignorance is bliss"). In the Contemplation stage patients are thinking about changing but are often ambivalent about it ("sitting on the fence"). The Preparation stage can be thought of as, "testing the waters," and getting ready to change. In the Action stage patients have initiated activities to change their behavior. During the Maintenance stage the patient focus is on staying on track with newly implemented behavior change. Since human behavior is often fallible, the SOC also identifies a stage known as Relapse when there has been a "fall from grace" and pre-change behaviors have resurfaced.

USING MI AND SOC: NURSING TASKS

Nurses can use the theoretical underpinnings – often called "the spirit of MI" (collaboration, evocation, and autonomy) in their shared conversations with patients in order to facilitate behavior change. These collaborative conversations can be conducted in the context of a nurse-led psychoeducational group. One strategy is to use what is called the ICR rating scale to gauge

constructs such as Importance, Confidence, and Readiness. With "0" being "not at all" and "10" being "very," group members can identify how important the behavior change is, how confident they are that they can make it happen, and how ready they are to initiate the behavior change. The nurse facilitator can encourage dialogue among members by asking questions such as, "What would it take to move you from (a low number) to (a higher number), as this activity allows patients to "talk themselves into" the desired behavior change. The nurse can also identify the area of most need – is it most beneficial to help the participant identify the importance (personal relevance) for behavior change? Or, if participants are indicating that they know it is important but lack confidence, nurses can construct confidence-building activities. If the participants have identified that the change is important and they are confident they can try, the nurse can guide a group discussion about readiness to act now ("What are the next steps here?").

Here are some tasks that may be used to facilitate and support behavior change using MI and SOC:

Precontemplation tasks:

- Validate the lack of readiness ("I hear you - this is not on your radar yet")
- Encourage re-evaluation of current behavior ("On the one hand, you are saying you like to be independent and on the other hand, when you don't tell your provider that you are not taking your medications you are putting yourself at risk for another relapse and needing treatment")
- Encourage self-exploration, not action ("It might be worth thinking about…")
- Validate feelings of loss and frustration ("From listening to you as a group, I feel like I am hearing like quitting [alcohol/cigarettes/drugs/etc.] would be a little like losing someone who has always been there for you. Let's talk about that for a minute.")
- Explain and personalize the risk ("What do you already know about ____ and how it puts you personally at risk?")

Contemplation tasks:

- Decisional balance worksheets
- Develop the discrepancy from current behavior to desired behavior ("You got as far as you did by doing the best you know how to do, so let's explore what else you might need to know because like the old adage, 'if you know better you'll do better'."
- Identify and promote new, positive outcome expectations (from a Pro/Con worksheet, focus on the benefits of behavior change)

Preparation tasks:

- Encourage all initial steps no matter how small (but do not use the "cheerleader" approach)
- Support continued talk of change (Use MI talk to evocate and support patient autonomy)

- Brainstorm for ideas and strategies from the group
- Engage in confidence building discussions: “what worked in the past that you could use now?”
- Link them to referral services if applicable, e.g. MOVE! Program, Tobacco Cessation, Exercise programs, etc.

Action tasks:

- Affirm the commitment to change
- Affirm the difficulties they are encountering (Don’t minimize/No platitudes!)
- Develop and/or use standardized change plan worksheets for participants to write out their change plans (will be more likely to stick to plans they construct plans themselves)
- Assess and support confidence level (often decreases in early Action stage)
- Re-visit feelings of loss and frustration and encourage group support

Maintenance tasks:

- Plan for follow up support
- Discuss potential pitfalls (“What might trip you up and what do you think you could do about it?”)
- Reinforce confidence building discussions (share success stories even if minor success)

Relapse tasks:

- Re-frame focus from blame and shame to “What did you learn?”
- Reassess ICR scale
- Assess barriers and how they could be overcome (“Hindsight is 20/20 – if you had it to do over again how could you avoid ____?”)
- Update written behavior change plan

Tool Kit I: Medication Education Motivational Interviewing Style

Psychoeducational Medication Group using Motivational Interviewing

EXAMPLE: SPMI patients

Target audience:	Inpatient MH/SPMI patients
Staff Responsible:	Registered Nurses
Leadership notes:	Group uses evidence-based best practice; Facilitation supported through Motivational Interviewing (MI) collaboration with participants; Complexity of material should be based on capabilities of selected patient cohort
Schedule:	50 minutes bi-weekly
Program Objectives:	As a result of attending and participating in this program, participants will be able to state the reason(s) why psychiatric medications are being provided to them; the name(s) of their medication(s); how to take medications correctly; and, what side effects to watch for and report to their nurse or provider.

Group Process

Opening the Group

Introduce yourself and your role
Confirm the purpose of the group
Describe length of the group
Briefly describe behavioral expectations

Lead by Asking Open-ended questions
Demonstrate Reflective listening skills
Guide by Summarizing sample interactions
Provide information as appropriate

Guide the Agenda

Offer options: i.e., "We can talk about medications that help with depression or anxiety or confused thoughts. Which category would you like to discuss first?"

Elicit participant choice: i.e., "So we decided that we are going to talk about medications for depression. Would someone name a specific medication for depression we could talk about?"

Information Exchange

(Empathic * Supportive of Self-Efficacy * Non-judgmental * Collaborative * Clear * Concise)

Providing Education:
Ask permission
Assess current knowledge
Avoid overwhelming patient with too much information
Check in frequently for understanding

Share Clinical Information/Offer Advice:
Ask Permission
Check patient's understanding of information
Compare clinical information to patient's experience
Ask for patient's interpretation
Sample: "John shared he is interested in the medication

Ask for return demonstration

Paxil. From the information we shared, we know that Paxil can be used to help with depression and anxiety. What do you make of this information?"

Confidence Statement (Genuine * Succinct * Realistic * Supportive of Self-Efficacy)

Confidence statements are based on the knowledge that: 1) All people have the capacity to make health choices, and 2) When they are truly ready to change, they will find a way to do it.

Caution! Avoid the following:
Promoting unachievable or unrealistic expectations
Embedding a judgment, such as confidence that a patient will make the "right" choice
Promoting the nurses' agenda without regard for the patient's expressed goals
Offering an expression that is not genuine

Sample Confidence Statements:

I am confident that should you decide to take medication for _____ as it is ordered, you would know what side effects to report

I am confident in your ability to ask for help if you had questions or needed help with taking your medications

I am confident that you will be able to work with your provider to find a medication that works best to relieve your symptoms

I am confident in your ability to take _____ correctly

Close the Group

Show appreciation

Affirm positive behaviors

Respectfully acknowledge decisions

Offer Advice if appropriate

Emphasize Choice

Express Confidence

Describe/Arrange for follow-up and link with available resources

Documentation

Create and save a CPRS template that covers the basic structure of the group including: day/time, topic(s), general feedback from the group, and specific observations of the patient (i.e., "Mr. ___ was an active/passive participant in the Medication Group today. He shared _____. He was provided with supportive feedback for his participation in group."

Adapted from materials in:

Dart, M. (2011). Motivational interviewing in nursing practice: Empowering the patient. Sudbury, MA: Jones & Bartlett Publishers.

Miller, R. (2009). My mental health medication workbook. Eau Claire, WI: PESCI, LLC.

Tool Kit J: Staff Evaluation Tool for Psycho-educational Groups

	Evaluation Tool (RN self-evaluation or Peer to Peer Evaluation)	Yes	No	N/A
1.	Start session on time.			
2.	Provide each person with a written work or Resource book.			
3.	Involve people in a short review of at least one main learning point from last session.			
4.	Engage people in reading content aloud.			
5.	Direct majority of questions to individuals by name (say name then ask question).			
6.	Help participants pronounce, define, and understand complex words, phrases, and concepts as needed.			
7.	Maintain a balance of input. Involve each person about the same number of times.			
8.	Use chalk/white board to enhance attention & conversation.			
9.	Provide positive feedback or relevant input, responses, questions, and comments.			
10.	Handle irrelevant, digressive, incoherent, disorganized, tangential, manic, and egocentric remarks in a non-critical, therapeutic manner.			
11.	Give concrete, real life examples that are relevant to lives of participants.			
12.	Encourage participants to identify personal examples of main learning points.			
13.	Use adult – to – adult tone of voice & interactions (avoid talking "down" to participants).			
14.	Employ humorous, fun, and/or creative approaches.			
15.	Provide immediate prompting for inattentive behavior.			
16.	If anyone leaves group, express the expectation that he/she will return shortly.			
17.	Circulate and check written work throughout the session.			
18.	Summarize the main learning points.			
19.	Assign homework if indicated. Ask for future topics.			
20.	Ask and encourage group member feedback/evaluation.			
21.	End group on time.			
	TOTAL SCORE			
	PERCENT			

Leader:_____ Date: _____

Class/Topic: _____ Reviewer: _____

Group Leader Strengths:_____

Tool Kit K: Sample Template for CPRS group note

Education Specific:

Veteran participated in a psycho-educational group with __(#) _ peers.

The goal of this group was to learn about ____(group topic) ____.

Objectives:

Gain a basic understanding of ___(group topic)____

Initiate/Explore how ____(group topic) ___ will affect the Veteran.

Gain an understanding about _____(group topic) ____concepts and how they apply to the Veteran.

Resources used for the group included: _____

Group discussion included topic such as _____

Written information to the Veteran was provided: ____(list handouts)_____

Veteran was encouraged to explore their thoughts and feelings regarding ____(group topic)___ in regards to their own mental health recovery.

Readiness to learn:

( ) Attentive

( ) Mildly distracted/disruptive, mild difficulty tracking topic

( ) Non-attentive

Veteran stated _____ and he or she was an active member of the group discussion.

Training Method:

( ) Verbal (facilitated discussion, Q&A, etc.)

( ) Written/Handouts

( ) Demo

( ) Audio Visual

( ) Tour

Evaluation:

( ) Indicates understanding of ____ (group topic) ____ by re-statements of information provided in group

( ) Struggles to provide verbalizations about the material covered. Needs repeated explanations, or needs to repeat demonstration.

( ) Patient unable or unwilling to learn at this time

Information Resources

The following is a list of some of the resources available online that has information that is either evidence based, or collective based on expert consensus. You may use these sites to gather information for groups or as tools for offering psycho-education materials to Veterans and their families during groups. This list is not all-inclusive, but offers suggestions on where to find accurate information.

GENERAL MENTAL HEALTH

National Institute of Mental Health
www.nimh.nih.gov

National Council for Community Behavioral Healthcare
www.TheNationalCouncil.org
To locate mental health and addictions treatment facilities in your community, use the Find a Provider feature on the National Council's website.

American Psychiatric Association
http://www.healthyminds.org/
Educational resources, brochures, and tools for all mental health diagnoses as well as information available in Spanish.

Mental Health America
www.mentalhealthamerica.net
Information on mental health, getting help, and taking action

National Alliance on Mental Illness
www.nami.org
NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of individuals with mental disorders and their families. This website provides many resources on mental disorders that are helpful for people who have experienced a mental illness and their families, including support groups, education, and training.

National Empowerment Center
www.power2u.org
The mission is to carry a message of recovery, empowerment, hope, and healing to those diagnosed with a mental illness. The center provides information and advocacy resources.

World Health Organization – Disability from Mental Illness
www.who.int/healthinfo/bodproject/en/
Information on the global burden of disease in various parts of the world, including burden due to mental disorders.

After Deployment.org
Wellness resources for the military community
http://www.afterdeployment.org
General Pdf books available for various diagnoses and self-assessment tools.

MOOD DISORDERS

American Foundation for Suicide Prevention
www.afsp.org
Provides information about suicide, support for survivors, prevention, research, and more.

International Foundation for Research and Education on Depression (iFred)
www.depression.org
Resources and education tools for depression prevention and treatment.

MoodGYM
http://www.moodgym.anu.edu.au/welcome
This CBT website has been evaluated in a scientific trial and found to be effective in relieving depression symptoms if people work through it systematically. This site teaches people to use ways of thinking that will help prevent depression.

Postpartum Support International
www.postpartum.net
Provides support, education and references to local resources.
Toll free hotline 800-944-4PPD (4773)

Suicide Prevention Resource Center
www.sprc.org
Fact sheets on suicide by state and by population characteristics, as well as on many other subjects.

QPR Institute
www.qprinstitute.com
Free eBook (downloadable) Suicide: The Forever Decision. As well as other resources for education about suicidal thoughts.

Agency for Healthcare Research and Quality
http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=647&PCem=110413
A guidebook for patients and caregivers of people with TBI and depression. Full of many useful tools to offer to Veterans and families.

Depression and Bipolar Support Alliance
www.ndmda.org
Provides screening tests for depression and bipolar. Educational resources for prevention, symptom management and treatment.

Bipolarcaregivers.org
http://www.bipolarcaregivers.org/
Offers information for caregivers of people with bipolar disorder including managing mental illness and how to deal with the personal impact of bipolar disorder.

Pendulum
www.pendulum.org
Provides information bipolar disorder.

NONSUICIDAL SELF-INJURY

Focus Adolescent Services
www.focusas.com
Designed for parents and covers a wide range of mental health problems; it has a section on self-injury. Information and resources only available 0900-1500 EST weekday at 410-341-4216

S.A.F.E. Alternatives (Self-Abuse Finally Ends)
www.selfinjury.com
Provides information about self-injury and information about starting treatment.
800-DON'T CUT (366-8288)

ANXIETY DISORDERS

Anxiety Disorders Association of America
www.adaa.org
Promotes early diagnosis, treatment and cure of anxiety disorders.

Anxiety Disorders Resource Center
www.anxietypanicattack.com
Provides questionnaires on panic attack, generalized anxiety, social anxiety, depression, obsessive-compulsive disorder, and post-traumatic stress disorder.

Anxiety Panic Attack Resource Site
www.anxietypanic.com/index.html
Provides information regarding a variety of treatments and resources.

Freedom From Fear
www.freedomfromfear.org

Provides information, screening tools, and other resources on many types of anxiety disorders.

Obsessive-Compulsive Foundation
www.ocfoundation.org
Includes information about obsessive-compulsive disorder, treatments, how to find a health professional with experience treating the disorder, and links to other websites.

PSYCHOTIC DISORDERS

The National Association for Research on Schizophrenia and Depression*
www.narsad.org
Provides downloadable fact sheets on psychotic disorders.

Schizophrenia.com
http://www.schizophrenia.com
Provides information, support, and education to family members, caregivers, and individuals whose lives are affected by schizophrenia.

SUBSTANCE USE DISORDERS

American Society of Addiction Medicine
http://www.asam.org/research-treatment/pain-and-addiction
Provides information on pain and addiction.

National Institute on Drug Abuse
www.nida.nih.gov
Provides information and education about drugs of all types.

Substance Abuse and Mental Health Services Administration
www.samhsa.gov
Information on substance use disorders of all kinds, with education a provider/treatment locator.

SCREENING SITES: online tests about your own or others' level of drug use with advice on cutting down or getting professional treatment.

Do I have a drug problem?
www.drugscreening.org

How much is too much?
www.alcoholscreening.org

MOBILE APPS FOR VETERANS

My HealtheVet:

Mobile Blue Button for Veterans:
http://www.northropgrumman.com/AboutUs/Apps/BlueButtonMobile/Pages/default.aspx
(iOS, & Android)

Mental health:

LifeArmor: http://www.t2.health.mil/apps/lifearmor
(iOS, & Android)

PTSD:

PTSD Coach: http://www.ptsd.va.gov/public/materials/apps/PTSDCoach.asp
(iOS, & Android)

CPT Coach: http://www.ptsd.va.gov/public/materials/apps/cpt_mobileapp_public.asp
(iOS only; will be available for Android devices in summer 2014)

PE Coach: http://www.t2.health.mil/apps/pe-coach
(iOS, & Android)

Mood, depression, and/or bipolar disorder:

T2 Mood Tracker: http://www.t2.health.mil/apps/t2-mood-tracker (iOS, & Android)

ACT Coach: http://www.ncpic.net/wp-content/uploads/2014/03/Apps-handout-for-providers-2014-02-12b.pdf (iOS only)

Positive Activity Jackpot: http://www.t2.health.mil/apps/positiveactivityjackpot (Android only)

Anxiety and stress:

Virtual Hope Box: http://www.t2.health.mil/apps/virtual-hope-box (iOS, & Android)

Moving Forward: www.startmovingforward.org (iOS only)

Breathe2Relax: http://www.t2.health.mil/apps/breathe2relax (iOS, & Android)

Tactical Breather: http://www.t2.health.mil/apps/tactical-breather (iOS, & Android)

Mindfulness:

Mindfulness Coach:
http://www.ptsd.va.gov/public/materials/apps/mobileapp_mindfulness_coach.asp (iOS only)

Mindfulness Meditation: https://itunes.apple.com/us/app/mindfulness-meditation/id312327144?mt=8 (iOS only)

Insomnia/sleep:

CBT-i Coach: http://www.ptsd.va.gov/public/materials/apps/cbti-coach-app.asp (iOS, & Android)

Smoking/tobacco cessation:

Stay Quit Coach: http://www.ptsd.va.gov/public/materials/apps/stayquit_coach_app.asp (iOS only; will be available for Android devices in 2014)

Weight management:

MOVE! Coach: https://itunes.apple.com/us/app/move!-coach/id878356988?mt=8 (iOS only)

Pain:

WebMD Pain Coach
(iOS, & Android)

TBI/concussion:

Concussion Coach: http://www.polytrauma.va.gov/ConcussionCoach.asp
(iOS only; Coming to Google Play/Android in 2014)

mTBI Pocket Guide:
http://www.t2.health.mil/apps/mtbi (iOS, & Android)

Parenting:

Parenting2Go: http://www.veteranparenting.org
(iOS only)

Biofeedback:

BioZen: http://www.t2.health.mil/apps/biozen
(Android only)

[NOTE: All mobile applications are free downloads to smartphones/tablets using the indicated operating system]

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