IDEAS

SOLUTION FOCUSED GROUP WORK IN A COMMUNITY MENTAL HEALTH AGENCY

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Therapists in a "generalist" community mental health centre sought a way to deal therapeutically with various "long-term" clients, including clients with substance abuse problems, psychiatric diagnoses and longstanding relationship difficulties. When various individual approaches had not seemed to be successful, the staff decided to institute group therapy sessions, but strove to establish these in a way that was consistent with the agency's existing commitment to a solution-focused approach. This paper outlines the process, for clients and therapists, of establishing groups which embodied solution-focused principles. The paper discusses the experience of clients and therapists, describes the process of establishing the groups and the questions which remain to be answered, and draws comparisons with more traditional approaches to group therapy.

The idea for a solution-focused group arose from working in an agency where brief therapy has been the philosophy of treatment for some time. This treatment approach has proved both efficient and efficacious in a time when the demand for client care has increased and staff funding has decreased. In particular, waiting lists have become a necessary evil and management has encouraged staff to find ways to reduce the time spent waiting for services.

The agency has a community focus where all clientele, regardless of income, are served. Staff at both ends of the County serve targeted populations of the chronically mentally ill, substance abusers, the mentally retarded population and youth and families, with difficulties related to relationship issues, sexual abuse, school problems and more crisis laden situations, such as suicidal individuals and those showing violence to others.

Several years ago the agency deliberately adopted a solution focused therapy orientation (de Shazer, 1985, 1988), with an emphasis on teamwork and consultation. What evolved was a pioneer Community Mental Health agency, specialising in solution-focused family and couples treatment. Thus, when we considered using groups in our work, it was natural that they too would reflect both the principles and the methods of our solution-focused approach.

Second, this group was conceived by staff who were working with particularly difficult clients who had been active in treatment at our agency for some time and whose original symptoms did

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not seem to be changing. Indeed, these cases were often the "worst of the worst" and various attempts through family therapy and other innovative interventions had been attempted, yet the clients remained at high risk, presenting with imminent risk to self or others, and therefore needed to be maintained in therapy.

All of these clients had been seen in regular outpatient therapy by one therapist, some several times. Although gains were reported, the majority of these clients continued to present again complaining of the same problem — such as depression, suicidal thoughts, inability to work or to move on with their lives. The therapists had a sense of "having given their all" to these individuals and were running out of ideas to help them become unstuck. Peer supervision and live team supervision involving all staff had been attempted; and some had been referred for partial hospitalization in our innovative Crisis/ Detox Program, where clients received intensive, normalising and creative therapy interventions.

During a routine supervision session, I commented that many of these clients were "repeaters" in the system and wondered aloud what it would be like to put them together and devise a solution focused approach to the group. The idea caught fire.

Last, the program consisted of a group of highly skilled, creative and energetic therapists who expressed a great deal of interest in taking on an innovative project. The staff routinely worked as a team behind a one way mirror and derived great benefit from helping each other with clinical input. Therefore, we decided that we could conduct a group in front of a mirror as well, so that all the therapists could participate in observing and offering feedback. Thus, this was a real team project.

Following a decision to create the group, the project date was set and the staff of 10 outpatient therapists[1] eagerly awaited the outcome of their efforts. What follows is an explanation of the guiding principles of the way in which the group was organised, a description of the composition of the group and a summary of outcome. Since this data is based on two 12 session groups offered between April and December, 1993, the results from both groups will be noted. An attempt will also be made to outline the differences between this 12 session group and the more traditional long term group work of Yalom (1985) and Rose (1977).

Group guidelines

We decided that part of our weekly staff meeting would be devoted to discussing the group and group progress. The concept of "group ownership" was important to us. We wanted the group to belong to the clients, as opposed to the traditional pattern whereby the leaders of the group "own" the power to determine the content and process of the group. Nonetheless, we had clear ideas about the "shape" we wanted for these groups, and we thought it helpful that we meet to discuss our expectations. Initially, we thought that the group should write its own group contract, but that we would specify two rules —(1) staying focused on the present and future, and (2) making a commitment to attending the group for 12 sessions.

We thought that these initial rules were important in order for clients to be able to focus on ***behaviour*** outside the group. The rule to commit to twelve sessions reflected our goal to build relationships between the members so that they could carry their friendships outside the therapy room. We felt that allowing "no-shows" would reinforce these clients' tendencies to isolate and not move forward. We saw these two rules as the basic foundation of the group structure which would provide a sense of safety and direction for the clients.

1. The group leaders were Ann Brown, Carmen Clark, Stephanie Hardenburg, Cheryl Hittinger, Kathy Jones, Sandra Kemp, Barbara McCulla, Eileen O'Byrne, Beth Turner and Betsy Strawderman.

Various other ideas were proposed —

1. The group should decide on a name for itself, which gave the group autonomy, direction and cohesiveness.
2. The group would be seen as a cross between a therapy group and a self-help group, with an emphasis being on therapist exit by the end of the time, so that the members could continue, offering support and able to call on others both between sessions and after the end of 12 sessions.
3. The group should decide if it chose to have refreshments available each week.
4. It was proposed that there be two therapists available to act as co-facilitators, and that these would rotate weekly. Thus, the entire staff would participate and no two therapists would become too entrenched in the operation of the group. The remaining staff were free to observe the group from behind the mirror.
5. Staff consensus was that the group belonged to the members, and as such, they were empowered to assist each other in forming goals and working to achieve the goals outside the sessions.
6. It was suggested that group members make a promise towards their goal — a behavioural agreement made each week, at the close of the group meeting, in order to externalise the progress made in group.

Sandra Kemp and Stephanie Hardenburg led the first group, where the contract was formulated. (The therapists' names are in ***bold*** in the following transcript).

Sandy: Welcome to your group. Let's go around and introduce ourselves and say what we'd like to achieve over the next 12 weeks.

Pam: I would like to find another job and act more socially.

Richard: I have trouble getting along with my brother. I need to get my finances straightened out, too, and maybe start a business.

Bobby: I'd like to try to get over my wife. We split up several months ago.

Stephanie: I'd like to see if this group helps towards the achievement of everyone's goals.

David: I'd like to work again and have some communication with my family.

Sandy: I would be very interested in how you make this your group over the weeks.

Stephanie: You know this is all brand new to us, this idea of a 12 session group. We would be most interested in what you think you need in order to make it work. Let me just start with some of the ideas staff had and you can incorporate these rules or come up with your own.

We outlined the six ideas discussed above were outlined, as well as the two rules insisted upon by the therapists. The group discussed each item and agreed to the two rules.

Sandy: We think it's important for you not to get bogged down by past failures. We are interested in your past as it relates to the way your past can help you make wise decisions about today and tomorrow. Therefore, we will be pushing you to stay in the here and now.

Bonnie: I am ready. It sounds like time for action.

Pam: I agree.

Stephanie: How about you guys? Richard, Bobby, David?

David: It sounds great. I am all for not being on the pity pot.

Richard: I guess, if that's what you think.

Bobby: I want to move on, one day at a time, just as NA [Narcotics Anonymous] teaches me.

Sandy: You know, another thing we have learned is that people who truly want to change come to therapy. You all need to work as a group and to learn to know each other and trust

each other. Do you all think you can commit to twelve sessions?

All the members agreed to this condition, and discussed what would constitute an acceptable excuse for absence. They decided that dire emergencies, such as a life threatening illness or traffic jams, were acceptable for lateness or missed sessions. Next, the group decided to name itself "Let's Get Busy". The second group came up with the name, "Pardon our Dust, We're Remodelling".

We encouraged members to contact each other between sessions and to socialise with one another. With a relatively small number of participants in this group and its short term nature, as well as the focus of the group being on specific behaviour rather than on less tangible "process", we did not fear the possibility of subgroups developing with some members feeling "left out".

We explained that all other group rules were to be formulated by the group itself and this led to an immediate group cohesiveness and to the members claiming equal ownership of the group. The members each signed a contract and the staff therapists came into the room and introduced themselves. Each member also identified their goals for the next 12 weeks and made a promise of an achievable action to complete by the next meeting.

The goals for each group member were identified in a behavioural context, framed by the therapists using the miracle question to identify what future success would "look like". From this, Pam decided to work towards her goal of socialising more by calling a friend on the phone; Richard decided to work on his employment goal by making fliers advertising his pony rides business; Bonnie decided to work on her resumé as a first step towards changing careers; Bobby decided to attend more NA meetings as a way of moving on from his divorce; and David committed himself to calling his father and having an "upbeat" conversation as a first step towards repairing things with his family. The goals, therefore, were broken into steps that could be taken each week to enhance the achievement of the larger goal. The members of the group helped each other with identifying these small steps.

Comparison to other group philosophies

This solution-focused group embodied several principles which are consistent in group literature. Yalom (1985) notes that all groups, by virtue of their existence, lead to curative factors. Some of these factors include instillation of hope, universality, cohesiveness, development of socialisation techniques and interpersonal learning. The solution groups reflected these curative factors and much more. The participants were asked to take responsibility for their futures by developing new goal-directed behaviours. They were empowered as individuals to become experts on their own behaviour and to assist each other, both in and out of group, by forming a self help support network. There were clear differences between this type of group and more traditional process or behavioural groups as described in the literature. Some of the important differences are elaborated in Table 1.

Summary of group composition

The first group comprised Pam, 32, an overweight, single female who was periodically suicidal and who had been unable to benefit from outpatient therapy; Richard, 30 a single male with sexual identity and sexual compulsivity issues, who had been unable to find work or leave home; Bobby, 35, who was separated from his wife and who had a history of ongoing polysubstance abuse; Bonnie, 48, a divorced female who wished to re-enter the job market; and David, 38, a single male who was cut-off emotionally from his family of origin, living in a railroad car and wishing to return to work for the railroad.

By the group's twelfth and final session, the fol-

Process And Behavioral Group Work	Solution-focused Group Work
1. ***Importance of the Co-Leader Dynamic***	
In a process group, longer term in nature, the leaders' relationship recapitulates the clients' families of origin. There is, therefore, a need for co-leaders to be constantly vigilant about how their personal issues and processes translate within the group.	The leaders and their relationship are not considered to be as important a factor, especially since the leaders change week to week. Also, leaders are viewed as consultants to the clients, and therefore are not in an hierarchically superior position. The group members are seen as equal leaders in their weekly meetings.
2. ***Assessment for a proper mix of group members***	
Behavioural groups are often formed on the basis of presenting problem. (All members have like phobias, for example.) In a longer term process group, Yalom (1985) advises that the group composition not be dominated by too passive, dependent or aggressive types; a mix of males and females is favoured.	Due to the brief, goal-directed nature of the group and the lack of emphasis on pathology or on changing clients' character structure, the mix of clients is less of a factor. However, it is felt that "assessment" of the two basic principles — a commitment to attend 12 sessions and a desire to stay in the present and move forward — is important.
3. ***Confidentiality / Contact outside the group***	
In most groups, confidentiality is to be maintained amongst members. There is usually a group norm which prohibits outside discussion of issues between members and others, as well as a sanction against group member contact between sessions.	Group members agreed that they would honour confidentiality between themselves. Since the group was seen as a cross between a self-help and a therapy group, members are encouraged to contact each other rather than the therapists for support. They also formed a social network by engaging in social activities such as picnics and bowling.
4. ***Duration of the group***	
The length of treatment for a behavioural group is dependent on the complexity of the problems, the homogeneity of the group, the specificity of the complaint and his or her own experiences (Rose, 1977). Many process groups are designed to allow relationships to form and change by allowing sufficient time to form the group as a microcosm of society. Often group members stay in a group a minimum of two years (Yalom, 1985).	The solution groups were purposefully formed to be completed in twelve sessions. The rationale for the concept of brief group included: 1) The future orientation, suggesting that change is more important in the external world than in the therapy room or within the internal processes of the client. This assumes that solution thinking, positive in nature, will lead to positive cognitive, emotional and behavioural change. 2) A brief format frames the clients as entirely capable of assuming control of their own lives and communicates a belief in their capabilities.

Process And Behavioral Group Work	Solution-focused Group Work
	3) The aim is to use therapy only as a springboard from which group members may continue in their self-directed network of support outside the therapy room. This is based on a philosophy of fostering independence from therapy vs. dependence on therapy.
5. *Measure of success and decision to terminate*	
Yalom refers to one group goal as providing a climate whereby a person's character structure may be altered. In his work with behaviour focused groups, Rose (1977) alludes to the decision to terminate being based on symptom alleviation or creation of an adaptable behaviour.	Success is defined by three criteria — 1. Client's assessment of success — "Have I achieved my goal and/or is my life in a better place now?" 2. Cessation of calls to the agency for ongoing treatment. 3. Reliance on the created support system of the clients themselves.
6. *The group as a microcosm of society*	
Given enough time in group, each participant will exhibit their maladaptive interpersonal style, and, as such, the group as a microcosm of society can help challenge and confront the person's dysfunctional behaviours. In behavioural groups, like adaptations will frequently lead to maladaptive behaviours and, as such, participation with others who set goals for change can reinforce progress (Rose, 1977).	The solution group is based on creation of realities rather than a recreation of the client's problems in interrelationships. Again, clients' potential is stressed and the culture of the group is framed as a healthy system of relationships.
7. *Contra-indications for inclusion of group members*	
In process groups, Yalom notes that there is considerable clinical consensus that patients are poor candidates for a heterogeneous outpatient intensive therapy group if they are brain damaged, paranoid, hypochondriacal, addicted to drugs or alcohol, acutely psychotic or sociopathic.	The following DSM III-R diagnoses have been seen in the solution groups — Borderline Personality Disorder, Impulsive Control Disorder, NOS, Polysubstance Abuse, Adjustment Disorder with mixed emotional features, Post Traumatic Stress Disorder, Dysthymia, Dependent Personality Disorder, Schizophrenia, Adjustment Disorder with Depressed Mood, Major Depression, Marital Problems, and Parent/child Problems. Therefore, it is felt that diagnosis does not determine successful outcome. However, it was demonstrated by trial and error that a sufficient assessment of the client's willingness to move forward was necessary for inclusion in the group.

Process And Behavioral Group Work	Solution-focused Group Work
8. ***Group leader function***	
Leaders in a process group are responsible for creation and maintenance of the group and for gatekeeping. "The therapist is responsible for all forces that threaten the group, such as tardiness, absences, subgrouping, extra group socialization and scapegoating" (Yalom, 1985). Rose (1977) reports on group leader function as providing clients with information, training on the application of principles and alternate treatment plans.	Solution groups operate on the premise that the clients are the true leaders in the weekly operations of the group. The therapists are consultants to the empowerment of the group so that, as the weeks pass, hierarchically the rotating therapists assume a lower, peripheral position in relation to the clients. This promotes rapid group cohesion, leads to positive behavioural experiences, esteem building and continued structural integrity of the group as it moves from a therapy to a familial mutual help experience.
9. ***Stages of therapy***	
In longer term groups, participants experience the initial stage of fitting in, survival of the group and feeling comfortable. As time goes by, the issues of power and control become evident. As the process unfolds, and belongingness is cemented, participants are able to achieve cohesiveness and eventually autonomy. In the behavioural groups which Rose describes, the content of the person's problem solving is central. Specific contractual conditions are more central to stages than is process.	There is a presumption in these groups that the final stage is the initial stage — that is, a belief that clients possess the necessary inner strength to form behavioural goals and to assist each other in their implementation. From that standpoint, the externalizing of the process to the outside world is more important than the internal processes/stages within the group meetings. This philosophy aids in the brevity of the treatment as well as in the overall emphasis on the healthy functioning of the clients. There is, in other words, a presumption of health rather than pathology.
10. ***Problem vs. Solution***	
Long term outpatient groups have as their goals to offer symptomatic relief and to change character structure (Yalom, 1985). Behavioural groups generally work towards alleviation or elimination of a dysfunctional symptom or towards creating of more adaptable behaviour.	Presenting problems are addressed with therapists asking for exceptions to the times when the problems occurred (de Shazer, 1985). Exceptions are then built upon by a focus on the clients' present and future thoughts, feelings and behaviours. Past issues are discussed only in terms of how present and future behaviour could be solution focused. This approach is based on the belief that clients' strengths should be stressed rather than focussing on their problems or pathology.

TABLE 1: Comparison of principles and methods of Process and Behavioural Group Work (Yalom, 1985; Rose, 1977) and Solution-focused Group Work.

lowing goals had been accomplished.

Pam reported having a full time job, was attending Overeaters Anonymous and was no longer suicidal. Richard began a pony ride and print business and no longer discussed his wish to become a woman. Bonnie developed a portfolio of her art and began seeking employment interviews. David visited his family, re-established a positive relationship and began a full-time job working for the railroad. Only Bobby did not continue with the group, having dropped out halfway through, after the group challenged him about his contacts with a motorcycle club. All thought his "armour" had been stripped away which, interestingly, was a strategy which deviated from the original concept of keeping the group interaction in the present and future. This "mistake" was thought to have led to his departure. This group, nonetheless, seemed to have achieved a high degree of cohesion, support for each other's efforts and much interaction both within and outside the group. Bonnie hosted a picnic for the members and all kept in touch with each other by phone. The last session was spent with the group agreeing to keep in touch and expounding their new commitments to themselves towards the ongoing goals they had defined.

The second group comprised Robert, 31, a single male who had never been able to leave home, and who was dominated by his parents; Ericka, 33, a single female who sought help in leaving her live-in boyfriend and who was looking for better employment; Brian, 21, diagnosed schizophrenic, who wished to work, return to college and learn socialisation skills; Ida, 35, recently separated from her sexually abusing husband, and wishing to go to college and better her parenting skills; Bonnie, 26, who was referred by our Crisis/Detox Program to learn socialisation skills; Pat, 45, who wanted help finding work and leaving her boyfriend; and Philip, 18, who had been in foster care and therapy for years and who identified the goals of finishing school, obtaining work and decreasing his bouts with enuresis.

Shortly after group ended, Robert moved out of his parents' home and was able to find employment as a radio broadcaster. He reported that the group was a wonderful experience, which enabled him to become unstuck and forward moving. Brian began to attend college, while working part-time in a fast food chain. Although he was reticent to initiate phone calls and social contacts, he agreed to go bowling with Robert. Ida began a full-time college course at the local community college, continued to improve her single parenting skills and wrote a book on her own sexual abuse experience. Philip began working part time, was continuing in his senior year in high school while making plans to enter the Job Corps and reported a reduction in bed wetting to once every month. Prior to his therapy experience, Philip reported enuresis occurring several times per week.

This group had three "dropouts". Ericka left after the first session. The staff had felt that she was higher functioning than the others and that her primary concern was the relationship with her boyfriend. Pat also dropped out after a few sessions. Unbeknownst to staff, Pat was involved in a physically abusive relationship and we felt that the effects of the continuing abuse prevented her from engaging in the group. Bonnie also dropped out of the group after several sessions. We felt that she had not been properly assessed regarding her motivation to work towards a goal and that continued participation in the referring program led to some distraction for her. (See "Outcome" section for more discussion of this client.)

Staff regarded that this group as somewhat less cohesive than the first. This could be due to the rate of dropouts or the particular personalities involved. Interestingly, the staff also seemed somewhat less energised about this group, noting that the "innovation" had worn off to a degree. Yet, in summary, the four remaining clients achieved above and beyond their (and our) expectations and, except for some less serious calls to the agency, all continue to derive maximum benefit from their solution behaviour.

A summary of the group composition and outcome appears in Table 2 (page 69).

Application of solution-focused principles to the group process

The application of solution-focused principles to the group began with a belief that the therapists shared, based on their conviction that the clients possessed the resources to find their own solutions. This seemingly simple concept involved a philosophy of change grounded in the therapist "staying out of the way" (and so not perpetuating those things that get in the way of change). The co-leaders were depicted as co-navigators steering the ship of change to stay on course, acting if the vessel veered towards negativity or actions which in the past had not worked. This is not to say that the group did not express pain, frustration and confusion, at times. In fact, it was the clients' humanness which allowed the group to seem genuine and which led to understanding and, thus, a belief in the direction towards positive change. Part of the co-leaders' role in these groups was to talk to each other and to reinforce the strengths presented by the clients.

Carmen: I've noticed that Catherine seems to be saying that no one likes her and that she never opens up to people, yet look what she has shared in these rooms.

Eileen: I agree with you, Carmen. How do the rest of you think that she was able to have that happen?

Steve: Yeah, that's right, Catherine. Don't you know you are one of the most honest, likable persons in the world?

Jane: I agree with Steve. Look at how much you share and the fun we have going to have coffee after group.

This interaction illustrates the refocusing of the group process towards a positive exception to old behaviour and belief systems and stresses the strength within the group to accomplish the goals.

Normalising each individual's problems, use of humour and building on small successes were consistent principles which guided all of the therapists in the group. The therapists involved each had different styles of interacting. Some were very directive, others much less so. One therapist thought it was important to remain silent through the meeting so that there was no impression that the therapists were being therapists. Most, however, stuck to the guideline of steering the group, commenting on positive behaviours and encouraging movement forward. Curiously, these varied styles seemed to have no impact on the group outcome. There was no dependent attachment to any one therapist, and the clients seemed to view the various therapists as equals. An excerpt from the second group will illustrate these uses of humour, normalising, building on clients' strengths and therapist/client equality.

Robert: I actually was able to call about the broadcasting job in Fairfax. I have an interview for next week.

Ida: That's wonderful, Robert. I told you we'd be hearing you on the airwaves soon.

Robert: That is if my parents get off my case about how ridiculous my career goal is.

Barbara: And what will you do to prevent that from happening?

Robert: Move out, that's what!!

Ida: *(Laughing)* You say that every week, Bob. Maybe what you need is a good swift kick in the rear.

Ann: Is that part of the contract, Ida?

Robert: I know, I know. But remember. I told them last week I would be leaving.

Pat: Good job, Bob. And you can do it again.

Barbara: How can the group give you the steam to get that engine moving?

Robert: Call me and remind me daily.

Barbara: What do you think group? Can you do that?

(All nod affirmatively)

Robert: By the way, I think we need to give credit where credit is due. Brian actually fulfilled a step towards his goal. I took him bowling on Saturday.
Brian: *(Smiling)* It was a good time.
Ann: Does anyone think Robert is caretaking for Brian a little much?
Pat: No, I don't think so. Brian thinks for himself.
Ida: Yeah, he seems happier.
Robert: Oh my God! You therapists - always looking for something. We're doing just fine without your input, thank you.
Ann: Well, I guess so. It is your group. Maybe you ought to meet without us next time.
Robert: That is a splendid idea.
Barbara: What you the rest of you behind the mirror think?
(Phone rings)
Ann: Consensus. You're on your own next time.

This interaction occurred well into the sessions (session 11) when the group had consolidated its cohesion. The line between a therapy group and a social support group was becoming fuzzier and fuzzier.

It is important to note that staff meetings also became more positive and exciting as staff discussed the progress of their clients. Their enthusiasm seemed to carry to the therapy room. When a client accomplished a goal previously unrealised, the staff expressed wonder and encouragement. There was a climate of "Hey, this stuff really does work in a group format."

The staff regularly planned ways to energise group members, compliments to make, feathers to ruffle (this took for form of confronting someone on an issue so that other group members would defend the person and help them formulate exceptions and new achievable tasks). Mainly, planning began with a belief by all staff that pathologising clients was not helpful and by a steady belief in the individuals' resources which could prevail.

Outcomes

Another solution group is currently being conducted at our agency. This will make sixteen clients served during three 12 session groups. Since most of these clients had been assessed as having long-term problems and/or as being in need of more intensive intervention, the consensus of both clients and therapists was that considerable progress had been made during the 12 weeks. In assessing the success of the group, the clients reported that having other people to talk to, call on the phone and connect with socially was critical to their successful outcome. As well, several clients reported that the focus on the present and future and the behavioural goal-directedness of the group allowed them to move forward. During the last session, clients decided for themselves whether they were ready to accept a diploma stating that they had successfully completed the group and were ready to "stand on their own two feet" and work on their own towards finding more solutions to their problems. This emphasis on client self determination was also thought to create an atmosphere of client readiness and independence.

The therapists generally concluded that the group experience was worth their time. Most stated that the group empowered their clients to take additional steps towards resolution of their problems. They also felt that staff members themselves had experienced a high degree of cohesion during the group planning time, which was an additional benefit to Community Mental Health therapists who are used to dealing with crisis after crisis with their clients.

In terms of follow up, only Philip has been seen on an emergency basis after his social worker insisted he seek further help after a fight with his foster parents. He stated that he did not feel the need for further therapy. Additionally, Bonnie called in regards to some school problems with

Name	*Age*	*Marital status*	*Previous diagnosis and presenting problems*	*Goal for group*	*Psych hosp?*	*Employed at start*	*Family support*	*Outcome*
Pam	32	single	Adjustment disorder with depressed mood. Weight, suicidal	Social life; get a job	yes	yes	limited	Successful. No more suicide
Richard	30	single	Impulse disorder NOS. Leaving home, employment, isolation	Start a business; leave home	no	some	none	Began business
Bobby	35	separated	Polysubstance abuse. Isolation, marital separation	Adjust to separation	no	yes	none	Dropped out of group
Bonnie	48	divorced	Adj't disorder with mixed emotional features. Employment re-entry, socialising	Enter profession; achieve social comfort	no	no	no, but connected to kids	Employed in a profession
David	38	single	Adj't disorder with depressed mood. Employment, family issues	Improve all cut-off relationships; get a job	no	no	currently estranged	Employed; reconnected with family
Robert	31	single	Personality disorder NOS. Unemployed, leaving home	Leave home; find employment	no	no	no	Left home; professional employment
Ericka	33	single	Adj't disorder with depressed mood. Relationship with boyfriend	Get a job; leave boyfriend's home	no	yes	yes	Dropped out of group
Brian	21	single	Schizophrenia. Isolation, unemployed	Go to college; meet people	yes	no	yes	Going to school; employed part-time
Ida	35	separated	Adj't disorder with mixed emotional features. Sexual abuse, single parenting, schooling	Go to school; face single parenting	no	no	none	Went to college; wrote a book
Bonnie	26	single	Depression, Borderline personality disorder. Depression, relationships	Not be isolated	yes	no	none	Dropped out of group
Pat	45	divorced	Adj't disorder with anxiety. Relationship with boyfriend.	Get a job; leave boyfriend	no	no	none	Dropped out of group
Philip	18	single	Enuresis. Parent/child probs, employment, school relationships	Get a job; finish school	no	no	none	Stayed in school; cessation of enuresis

TABLE 2: Group composition and outcomes

her daughter, which the therapist feels can be handled by phone, or with two to three sessions. For this population of clients, who are used to relying heavily on the Community Services, we believe that no further contact is a sure sign of success.

In summary, some important statistics have emerged pointing to factors to be considered in group selection and successful outcome.

The most salient factor in group attraction and cohesion appeared to be the social isolation factor amongst members. Of the three dropouts, two had entered initially requesting help with a significant other relationship. All of the successful participants were either single, separated or divorced. Of the 9 successful clients, only one reported a satisfactory relationship with his extended family. What seems to have occurred, then, was a creation amongst members of a "family" support system. It is unclear whether this phenomenon would have occurred amongst members with adequate family support, but we suspect that this might not be the case. Another interesting statistic emerges around the employment status of the clients at the commencement of the group. Two of the three dropouts were employed. Only 20% (or 2) of the remaining clients were employed and, in fact, all of the nine clients nominated improved employment or school as a goal.

Based on our experience, there are two factors which need to be emphasised when assessing the success of the group. This reflects our opinions as to why the dropouts occurred and are not likely to be the only factors limiting the effectiveness of the experience. As our experience continues, other factors related to success or failure may be identified.

The first factor appears to be the need to assess thoroughly the client's willingness to enter the group, his or her agreement to move forward with identifiable goals and his or her motivation to commit to attending twelve sessions. This is achieved through a process of discussion between client and therapist, before joining the group.

The therapist discusses with the client what parts or aspects of therapy have been helpful in the past, and which have not been. Almost invariably, the client identifies those things which are a source of relapse. That is, the client reverts to describing (for example) his or her "depression", inability to achieve things, and the focus easily reverts to past hurts and failures. The therapist then agrees that there is much in the past that has not worked, but indicates that a group is beginning which focuses on moving forward, taking action and coming up with solutions. "You are a perfect candidate for this group, and might be able to be a resource for others in the group".

Interestingly, most of our clients have been so used to therapy that they are easily willing to enter a new form of treatment. It is almost as if these are people who "enjoy" therapy. Certainly, they are people who have developed a degree of trust in the Mental Health Center.

Within such an interchange, clients have usually responded well to the suggestion that there are concrete behavioural changes that they might like to make, and with which the group might help. Perhaps it is refreshing for them to be introduced to a new therapy experience with a focus on the things that they can do rather than the more traditional manner of clarifying their thoughts about the sources of their problems.

In the case of Bonnie, no such assessment was completed as she entered the group directly from another program in our agency. As for Pat, we thought that many of her issues centred around an abusive relationship with a boyfriend and that the immediacy of this prevented her from focusing on goals for herself. Ericka, also, appeared to be struggling with a relationship issue and probably could have been better served through couples therapy.

A factor common to the other, successful clients appeared to be that of singleness, separatedness

or divorced status. In other words, they were individuals with the least amount of social supports. This factor has continued to be paramount to the persistence of the relationship connections (the self-help factor) from within the group to outside the group.

The importance of this variable requires further consideration and it raises the question of the relative contribution of the solution-focused nature of the group compared to the social support aspect. My opinion is that the factor of singleness contributed to the development of social interaction between group members outside the group, whilst the solution-focused emphasis determined much of the direction within the group. Perhaps people with established social networks benefit less from the groups' transition from therapy to self-help and support, and so might be less likely to persist.

Of course, even if the major outcome of the group is the building of social supports, the fact remains that a group of "recidivist" clients, after twelve group sessions, have largely not returned to the mental health system for further help.

Future considerations

It has been suggested that only one therapist would be needed to run these groups. It has also been proposed that the clients themselves could conduct the group with the therapists participating only as consultants behind the one way mirror. Another idea is gradually to phase out therapist involvement (from two therapists to one therapist, to no therapist) as the weeks progress. This is similar to what evolved in the second group, when the clients "fired" the therapists in session eleven. More experience and reflection on different forms of therapist participation and the effect of therapist involvement is needed. Another idea is to have graduating clients return to act as co-leaders for the new groups. This idea was rejected by the therapists because we felt that the clients' participation as leaders would detract from their equal status in helping one another and from continuing to offer support outside the group as "graduated" individuals. To date, the groups have not been organised around a specific problem/goal, nor have variables such as gender, diagnosis, or age been considered in forming the groups. Future experience with solution goal-directed groups will, perhaps, lead to more verifiable conclusions.

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