

# First Things First: How to encourage and motivate clients in their group work firsts (first contact, first interview, first group) using the Needs ABC Model

by  
Tom Caplan, MSW, S.W., F.T.M.  
Adjunct Professor  
McGill University  
School of Social Work  
Email: tcaplan@sympatico.ca

L'outil Needs-ABC peut être utilisé lors des premiers contacts avec un client afin de l'encourager à s'impliquer dans sa thérapie.

The tool Needs ABC (Needs Acquisition and Behavior Change) can be used in a client's first contact to encourage him to engage in his therapy.

## Things to Consider

Although there has been some movement towards group member empowerment during the therapeutic process (Jenkins, 1990; Miller and Rollnick, 1991; Mullender & Ward, 1991; Caplan, 2005a), the issue of the individual's first contact with a helping professional, frequently by phone or e-mail, etc., has not been given a great deal of attention, with the exception of simple "advice giving" by experienced practitioners on how to deal with applicants for individual therapy over the phone (Goldstein, 1999; Caplan, 2005c; Nuttall, 2005). A review of the literature indicates that many group workers assume that the presenting group member is ready to participate in the process of exploring new ways of thinking and behaving (Liebenberg, 1983; Anderson & Stewart, 1983; Froberg & Slife, 1987; Verhulst & van de Vijver, 1990). In fact, resistance to treatment may have a lot to do with the context within which treatment occurs (Anderson & Stewart, 1983),

which can include systemic barriers such as court and institutional restraints, interactional issues such as cultural differences, and the group worker's own perspectives and needs with regard to what is expected from a group member. A process of change can make anyone apprehensive, so it stands to reason that many group members are "on their guard" when taking the first step towards seeking help. Yet the promotion of effective therapy still appears to hinge on the concept of minimising the acceptance of "resistant group members" into treatment or labelling them as problematic (see Greenson, 1967). While a first client contact provides the intake worker with the opportunity to assess the suitability of potential group members for inclusion in current or planned therapeutic groups, they also provide the opportunity to encourage individuals to take positive therapeutic steps and to facilitate engagement in the therapy group.

Several researchers and group work theorists regard the screening interview (Nicols & Schwartz, 1991; Maione & Chenail, 2004; Toseland & Rivas, 2005; Yalom, 2005) and the first group work session (Shulman, 1999; Vinogradov & Yalom, 1989; Rose, 1989; Doel & Sawdon, 1999) as essential to the work that follows. Challenging a group member too quickly can lead to defended participation as can deferring an intervention for too long (Caplan, 2005b). For example, in their research article on client engagement, Noel and Howard (1989, 798-805) state:

It is important to note that in this treatment setting it was expected that patients would proceed through the screening process before a decision was made about their acceptance for psychotherapy and subsequent assignment to a clinician. Patients were prepared for this process during the initial telephone interview and were unlikely to expect therapy to begin with the first visit to the Institute. Thus, some of the possible negative consequences of being transferred to a different clinician could have been moderated by the

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clear procedural expectations. In addition, a positive initial experience both with the telephone intake worker and the screening clinician, may enhance a patient's expectation of receiving help from the assigned therapist. It is possible that when patients feel they are likely to receive the help they want after the screening process, they begin to form a relationship to the institution, not just to the screening clinician.

Therefore, not understanding group members properly can silence them, while making observations too quickly can be intimidating. It is this author's opinion that the first group member contact can be just as important as the first session in motivating and encouraging group work group members to take responsibility for their participation in the group (Jenkins, 1990; Miller & Rollnick, 1991). Furthermore, the initial contact can help to promote group member accountability, offer tactics for "saving face" and suggest strategies to help the group member to risk lowering defences (Greenson, 1967; Anderson & Stewart, 1983; Goldberg Wood & Middleman, 1992).

This paper describes important considerations and strategies for group workers to use when individuals apply to join their groups, to help them to integrate as smoothly as possible into the group setting using the Needs Acquisition and Behaviour Change model (Needs ABC) (Caplan, 2005c; 2008). The author will provide examples of how this model is used in a client's first contact with a pertinent resource (in this case over the phone), a screening or "first" interview and in a client's initial group session. A case example will be used to illuminate the concepts described (adapted from "First Impressions: Treatment considerations from first contact to first group". *GroupWork*, 15 (3), 44-57).

### **The Needs ABC Model**

The Needs ABC approach focuses on isolating and putting into practice useful, pragmatic solutions to the problems facing the individual. In some ways it echoes Edward Teyber's approach which says (Teyber, 1997: 44): "a primary working goal for the therapist is to provide validation throughout each session by grasping the client's core messages and affirming the central meaning in what the client

says." In this way, the Needs ABC model stipulates that without an understanding of the unmet needs that lie behind a client's dysfunctional behaviours and the emotions they predict, it is difficult to create lasting change (Caplan, 2008; 2010).

The Needs ABC Model was originally developed in the School of Social Work at McGill University's Domestic Violence Clinic. It uses observation and elucidation of a client's relational process combining group member, group worker, contextual and environmental process (Shulman, 1992; Caplan, 2005a) with cognitive-behavioural/motivational (Miller & Rollnick, 1991; Ellis, 1997), narrative White & Epston, 1990; Myers-Avis, 2004) and emotion-focused work (Greenberg & Johnson, 1988; Greenberg & Pavio, 1997). The overriding premise of this model is that a client's unmet relational needs will predict a more or less useful emotion, and that a less useful emotion will predict a less functional problem-solving strategy. If the relational need is defined, and a more productive emotion is determined, treatment planning can be done around a more appropriate acquisition of the need. Once the need has been acquired with a more useful emotional approach, the client will no longer experience the emotional need to engage in the destructive behaviours that have brought him or her to therapy; a functional relationship will ensue and more appropriate problem-solving techniques will be assimilated (Caplan, 2008; 2010).

What makes the Needs ABC approach different from the many other models available to therapists is that while it draws on the wisdom and experience of many therapists and therapeutic writers, acknowledging a considerable debt to clinicians working with a range of models, the Needs ABC Model is distinguished by its emphasis on *the relational needs behind maladaptive behaviours, and the emotions they provoke*, rather than the behaviours themselves, and by its flexibility in terms of application to clients in a range of personal and therapeutic settings. In the context of providing therapy, it offers a unique approach that helps clients understand the origins of their problematic behaviours individually and, in the context of their presenting problems, formulate more constructive ways to react to stress. By de-emphasising

behaviour and emphasising emotion and need, it becomes easier for clients to access the reasons that lie behind their problems, and to work constructively towards solutions (Caplan, 2008; 2010).

For example, a man may consistently present with “anger” and express himself using angry words, while self-exploration may reveal the more strongly felt sentiment lying beneath the anger to be a deeply felt sense of hurt because he cannot get as close as he would like to the people he cares for, and in particular to his life partner. The way in which he reacts to this “anger” (hurt) is likely to be problematic and may relate to the way he reacted as a child when he attempted to have his relational needs met in the context of his family of origin. Similarly, a woman might present with “sadness” and express herself using sad words, but might similarly discover that the underlying emotion is really anger at a lack of validation in her personal relationship. Accessing her anger may then help her to assert herself, while feeling sad might only maintain her position of perceived impotence and victimhood. Of course, while anger and sadness are, respectively, stereotypical expressions of emotion by men and women, these examples could equally well be reversed (Caplan 2008; 2010).

### **First Contact**

Jeanette’s first contact was over the phone. Jeanette, a 43-year-old, who had been married twice before and had no children of her own, called a substance abuse intake worker and anxiously told him that she had been both verbally and physically violent to her husband, Louis. She said he had asked her to leave when she did this in front of his two children (8 and 11) from a previous marriage. Louis told Jeanette that she was “a drunk and a lousy parent when she drank.” Originally, Jeanette had come to Quebec with her mother from Joliette and described her as “impossible to please” and “only interested in herself.” Yet when Jeanette was asked to leave, she went to live with her mother. Here, it appears that Jeanette might be indicating that the only person she can trust, despite her feelings of inadequacy in the relationship, is her mother. Jeanette acknowledged that she had become

aggressive on the few occasions when she drank and that her husband had asked her to leave but permitted her to return home each time. Jeanette stated that Louis had threatened divorce on those occasions but this time he had filed for divorce stating that she could only visit her children if she sought treatment for her problem. Jeanette had previously entered treatment once during their marriage because of a similar threat by Louis to leave her. This time Jeanette seemed more committed to dealing with her drinking and had begun to go to AA on a regular basis. She appeared to sincerely acknowledge that she had reached the critical point where something had to change, regardless of whether or not she could reconcile with Louis. In other words, Jeanette seems to be saying that she is more motivated to deal with her problem now that she is able to make decisions on her own behalf rather than on behalf of others (e.g. her husband).

Jeanette continued to show a great concern over what to do in her circumstance. Over the phone, Jeanette said:

“I know I have to change. I’ve been in treatment groups before, but I realise that I have yet to change my attitude. What I continued to do didn’t get me very far. I want to learn from my past mistakes and to own my behaviour, like you said.”

She added:

“I’m also really depressed. I know I’m completely responsible for what’s happened. I loved my husband very much and all I can think about is when we were one happy family. I come from a family where my father left my mother and my mother has basically humiliated me for 45 years. I never spend time with Louis; he is either away on work or doing stuff with his kids...and now he’s gone, too. This group is my last resort. If I can’t get help here, I don’t know what I’m going to do.”

With this in mind, the worker might consider that part of Jeanette’s fear may be about not only feeling inadequate with her mother but also incapable of succeeding in her pursuit of success in dealing with her addiction. Overall, a supportive and non-judgemental approach would be important in working with clients in general, and with Jeanette in particular, because of her fears of inadequacy (incompetence) and betrayal (fearing that she will be

taken advantage of or punished). Therefore, having a screening (first) interview administered by a worker trained in the same approach as the intake worker above (Needs ABC) would be especially pertinent.

### **The First Interview**

The importance of initial telephone contact notwithstanding, it is universally understood that all therapies require a screening interview, or assessment, to evaluate clients' status, state of mind, appropriateness for specific types of treatment, support, etc., as well as obtaining information about contraindications to immediate therapy, such as the presence of serious mental illness, domestic violence, or a substance abuse problem (Gottman, 1999; Jacobson & Margolin, 1979; Nichols, 1987; Caplan, 2005c). While clients in which such problems are present can benefit from therapy, it might be necessary to address these important underlying issues first. Meeting with clients for the first time can also provide an interesting view into just how differently they feel about the source of their problems (Gottman, 1999; Jacobson & Margolin, 1979; Nichols, 1987). For example, a husband calling for the first time with regard to a couples' group might say that his wife is unhappy because their children have left for college, while the wife might say that the problem is her husband, who is feeling threatened by her plans to return to full-time work after 15 years of working just part-time. They may both be right and wrong in equal proportions, but the underlying problem will invariably be the fact that each has certain relational needs that are not currently being met in the context of their relationship with each other. This is the root issue that will need to be explored in therapy, quite apart from any practical problems relating to their life and work situations and to specific circumstances they are currently undergoing. The first client interview, therefore, serves not just to obtain some basic information about them—although this is clearly very important—but also to start to build a rapport between the clients and the therapist (Horvath & Greenberg, 1994: 7; Johnson, 2004), something that is crucial if they are to feel like they are in a safe place where they can discuss their more intimate concerns and anxieties without risk of being blamed,

ridiculed, or condemned for the things they do and feel (Gottman, 1999; Johnson, 2004).

The screening interview with a client may, in some cases, suggest to the therapist that some practical issues may mitigate against group treatment for the time being or that other interventions might also be necessary concurrent with the therapy. If a client presents with substance abuse problems, for example, or if the potential participant seems to be depressed, it will be necessary to formulate a strategy to help deal with these problems in addition to embarking on therapy or even before therapy begins. For example, in the case of substance abuse, a client might be encouraged to attend a 12-step program as well as therapy, and in the case of a severe underlying psychiatric problem, the condition will certainly have to be stabilized and most probably treated with medication, possibly for the medium to long term. This is not to say that such issues are necessarily a contraindication to therapy per se but merely that the practical ramifications should be dealt with first.

As well as working toward understanding the nature of clients presenting for therapy and obtaining information on their personal view of what has brought them there, initial contact is also the right forum for obtaining basic personal details including the point at which the presenting problem seemed to manifest itself, the level of education obtained by both members of each couple, the pertinent couple background information, the presence or absence of children in the family home, and their relationship with their children and the nature of other important relationships. Overall, it is important to focus on a client's relational needs. In this way, there will be continuity with respect to this non-judgemental, supportive, approach and consideration of what the clients are asking for in their relationships (their relational needs).

### **First "Face-to-Face"**

In her screening interview, Jeanette not only continues to sincerely express her desire to change but also gives indications of her fears to do so. She, once again, shares the litany of unpleasant experiences and failures that she had reported to the telephone intake worker

indicating the concrete way in which she tends to view the world as a series of negative events. As well, Jeanette persists in reminding the worker that her application for treatment is independent of saving her marriage; that she “needs to do this for herself so she can move forward in her life.” She may be saying to herself: “I’m scared you won’t believe me. I don’t want to be punished or led astray. I’ve been punished and humiliated enough. What I really want is confirmation that I’m not a sick person and recognition that I have decided to get help. I hated being in treatment. What if I can’t succeed after finishing this one? Even if I am successful, I’m worried that no one will be able to see what I’ve accomplished. If no one can trust me, why should I even try?” Again, issues of trust and competency seem to be extant, as well as a fear of potentially being judged.

In the screening interview the worker could pick up on Jeanette’s apparent feelings of futility and fear and think: “The prognosis for this group member is rather poor since she’s been in a previous treatment and barely made it through. For her to have any chance at success this time would be a small miracle. As well, how can she even begin to limit set if she can’t save her fights for when his kids aren’t there? If I accept her into treatment, I am going to be held accountable...and what if she fails again?” Here, the intersection of relational, systemic and contextual issues can be predictive of a negative group member impression leading to a pessimistic prognosis. Jeanette might, therefore, enter the treatment milieu prophetically labelled as a failure.

### Encouragement and Motivation

In order to encourage and motivate Jeanette, the challenge for the intake worker is to validate her concerns, examine possibilities for future needs acquisition strategies through the themes embedded in her conversation, and simultaneously help her to set limits around behaviours that might disrupt her chances of beginning group work. On examination, Jeanette’s narrative reveals a number of possible themes that can be addressed. For example, when Jeanette laments the absence of her husband on business, she might be describing her feelings of emotional *betrayal*. When she

describes her attempts at controlling her drinking and her relationship with her mother, it is probable that she is describing feelings of *powerlessness* and *incompetence* in her life. With this in mind, the group intake worker can make either of the following emotion-focused process statements:

Group worker: *I imagine it must make you angry to feel you cannot keep those you love close to you.*

Or,

Group worker: *I think a lot of people in your situation would be very frustrated feeling that so much of their lives are out of control.*

These statements recognise the disappointment Jeanette feels at having little or no power over the degree of intimacy she needs from others and that she cannot control her relational environment. When Jeanette uses the phrases “Learn from my mistakes,” and “If I can’t get help here, I don’t know what I’ll do,” she may be indicating her vulnerability to exploitation by others. The group worker might acknowledge these feelings of apprehension in the following empathic way:

Group worker: *It must be hard to let your guard down considering all you’ve been through.*

In order to challenge Jeanette’s certainty that she must constantly be punished for speaking up, the group worker supports her lack of confidence rather than challenging it. To Jeanette’s expressions of powerlessness with regard to controlling her life situations, the group worker could offer this:

Group worker: *If I were you, I would be really angry at myself thinking that I can never get things to go my way.*

Here, the group worker has picked up on the possibility that some of the anger might be self-directed and has modelled appropriate self-disclosure. As well, this is an acknowledgement of her self-felt futility in the world and possible feelings of loneliness, potentially accounting for her drinking problem. However, even if the group worker does not pinpoint the exact relational issue that Jeanette has been struggling with, he or she has modelled disclosure of feelings to her and she could respond either by agreeing that the group worker has largely understood her point of view, or say something like:

Jeanette: *"I wouldn't really say I was angry. 'Bitter' describes it better. I am very bitter, sad and disappointed with the way my life has turned out."*

Towards the end of their conversation, the group worker's task is to leave the potential group member with some feelings of encouragement and motivation to proceed to her next group work experience. This group worker decided to summarise and validate Jeanette's concerns in the following motivational way:

Group worker: *You know, Jeanette, it is impressive that, despite all odds, you are still not willing to throw in the towel. If you are nervous that you might not succeed this time either, that's perfectly understandable, but your need to feel like a family, included and needed, seems to have driven you to desperate attempts to get your needs met. I think that you would find it useful to start working with a group that is being facilitated by my colleague Justine. I think you will like her. I am sure she will understand where you are coming from, and that she will help you to get to know the other people in the group. A lot of people find it useful to work with others who are in similar situations. I'm pretty sure that if we can help you to understand and clarify your emotional needs, then you can help us and the rest of the group to help you plan a better way to get them.*

By suggesting to Jeanette that she can be the choreographer of her treatment, Jeanette can begin to feel more empowered by using the treatment process as a metaphor for her life. Helping her to consider a concrete goal that can be modified as she moves along her treatment path is more likely to help her to feel encouraged and motivated by her treatment experience.

If Jeanette is still not convinced that she can follow through on her initial decision to come into treatment despite all the group workers efforts, and feels so self-defeated that, rather than being encouraged by the intake interview, she becomes more discouraged, the goal, then, would be to attempt to engage Jeanette in continuing to consider options for her problem. For example, the group intake worker might suggest alternative resources appropriate to Jeanette or offer her the opportunity to meet or speak on the phone again to revisit her options. Overall, it is important to focus on and acknowledge the potential group member's needs and encourage the member to examine needs-getting possibilities. In this case,

Jeanette's feelings of powerlessness to change things ("I imagine it must make you angry to feel you cannot keep those you love close to you"), inability to trust ("It must be hard to let your guard down considering all you've been through") and inadequacy ("If I were you, I would be really angry at myself thinking that I can never get things to go my way") would be important to revisit in the group.

### **First Group**

During the initial contact with Jeanette, over the phone, she appears to have high emotional needs for reassurance and validation of her experience as "victim." She also seems to expect that the group worker and/or the group will eventually punish and humiliate her. Jeanette's seemingly overwhelming situation could be based on her fear that she is an incapable and unlovable person, and that she is forever the victim of alienation. Jeanette appears to feel that, no matter how hard she tries, she can't attract anyone's positive attention. This view underlies several emotional themes that emerge in the context of group therapy during the weeks to come, including her fear that she is not worthy of love for love's sake, that all her relationships are conditional, and that she can't do anything to change her life.

Research has shown that the applicant's perception of the group intake worker is predictive of retention in the therapeutic domain (Noel & Howard, 1989; Mohl, Martinez, Ticknor, Huang & Cordell, 1991). That is to say, the more positive the experience, the more likely the group member will remain and engage in treatment. They should experience the interview as an offer to participate in group therapy, rather than a "test" to see what is "wrong with them." Furthermore, the more informed group members are about what to expect during the treatment process, the more likely they are to continue (Westra, Boardman & Moran-Tynski, 2000). This is especially true if the group facilitator is the one doing the intake interview (Noel & Howard, 1989).

The group intake interview is, in fact, a "first therapy session" (Caplan, 2005c) for the prospective group member (the Needs-ABC model encourages the use of the same person

for all group member contacts, though, admittedly, this is not usually possible.) This implies that the way in which the group member views the group worker, and the degree to which the group member takes responsibility for the therapy (see Orlinsky, Grawe & Parks, 1994), impacts strongly on the course and outcome of the therapeutic experience. Group member expectations are the same as if they were to proceed to individual treatment, so “joining” and other important therapeutic skills are being tested.

For example, from an empathic point of view, many intake workers might feel the need to challenge Jeanette’s fears and frustrations above with statements like: “I know it’s horrible not to feel trusted, especially by those you love. I suppose if you could have controlled your drinking things would have gone better for you.” Or: “Anyone would be angry at feeling that those who are important to you cannot trust you, but I guess when you lost it in front of his children it was ‘the last straw’.” Both of these interventions appear empathic and supportive. However, given the above case history, this focus on behaviour also reinforces her reality; that she has been powerless to change the more shameful behaviours that she has perpetrated. This could reinforce her sense of discouragement and her fear that she will be punished for her transgressions. For example, she might think: “Even the group worker thinks I’m bad. How could I have done what I did in front of those kids? Why can’t I stop my drinking when I want to? Why am I even trying to get help...again?”

### **Needs ABC: An Optimistic Approach**

Helping the group member to develop a sense of optimism is fundamental to any clinical interview, and is especially important in an evaluation for group work. Giving the applicant the possibility of feeling more in control of the therapeutic process will enhance feelings of safety (Caplan, 2008) and hope (Yalom, 2005; Pretzer and Walsh, 2001). With regard to Jeanette, one of her group workers was assigned to her case, having been apprised of the content of her discussion with the intake worker. She offers a more optimistic intervention by saying: “I know it’s horrible not to feel trusted, especially by those you love. I suppose

that one of the things you could have the group help you with is how you could redevelop the trust in others that you need to keep them close to you.” And later added: “Anyone would be struggling with difficult emotions if they found themselves feeling a lack of trust and powerless to do anything about it. It might be helpful to bear that in mind. Perhaps you could consider sharing this in group so that, together, you can figure out how to get some power back, rather than giving it up to your drinking or to your more negative feelings.” In this way, the worker is offering Jeanette an opportunity to take charge of her treatment by giving her some suggestions as to how she can begin her treatment, as well as some therapeutic goals to aspire to. In closing, the group worker could say:

*Anyone considering joining a group is usually struggling with confusing feelings, like the bitterness and disappointment you mention, or emotions such as anger at others for not trusting you, and at yourself for not being able to succeed as a family; fear and sadness about how you have tried to resolve your problems only to sabotage your efforts. When you start group therapy, you can bring the issues that have been making you unhappy to the group and begin your work by knowing that you have something honest to share. Perhaps you could even consider mentioning that, despite everything, you have not given up. Something to be proud of, eh?*

These suggestions help Jeanette to collaborate on a concrete plan for her participation in the group while still allowing her to make choices around when, with whom, and what to share. There is no doubt that Jeanette will still be anxious about her next therapeutic experience, but now she will have some sense of power from knowing what she can take with her into her next course of treatment.

### **Conclusion**

A prime directive of effective group work is that the group member must feel emotionally safe in the group setting. By giving Jeanette something to “hang on to”, the intake group worker has provided her with some simple interpretations that she can rehearse and present at the beginning of her group experience. This can help her to feel more comfortable in her initial participation while she is evaluating and adjusting to her group experience. Any one

need of Jeanette's that is effectively recognised and validated by the group members will not only further include Jeanette in the group but will also include the group in her story, building group cohesiveness and helping her to feel more included and less vulnerable.

Jeanette's unresolved grief and her apparent emotional difficulties around issues of trust seem to have resulted in a deep-seated resentment, and she seems to have displaced many of her angry feelings from her family of origin (particularly from her parents) onto her husband. She would appear to have feelings of being cast out on her own, being ganged-up on by her husband, mother and the legal system, and being victimised by a double standard whereby her husband can provoke and yet "escape" treatment (punishment). Her compulsive use of violence, threats and other gestures of intimidation are probably attempts to gain some mastery over her fears of a loss of loyalty in the hopes of controlling her environment in this way. As well, because of her pessimistic worldview, Jeanette may very well anticipate punishment by the group.

In conclusion, from the outset, intake worker, group member and group worker can feel more optimistic about the therapeutic process when consideration is given to a group member's vulnerabilities, needs, and life experiences. By being supported and guided in taking charge of the work they must do in the treatment milieu, this "taking of responsibility" can be a powerful metaphor for group members with regard to what they must continue to do on their own beyond the treatment setting. By shifting the onus for doing the therapeutic work from the group worker to the group member (Ormont, 1993) group members can direct the treatment towards their individual therapeutic needs (Caplan, 2005b) and do so at their own pace.

#### Descripteurs :

Entretiens (Service social) // Needs ABC (Needs Acquisition and Behavior Change) (Outils d'intervention)

Interviewing in social work // Needs ABC (Needs Acquisition and Behavior Change) (Tool)

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