Bipolar Disorder Group Therapy

Overview Group

The group that will be looked at in this paper will be African American Men with Bipolar disorder (BD). This group will be closed and voluntary. A closed group is essential because members will not have to have new members come and interrupt the progress they have already made. Having a closed group will also be necessary because the group is building and learning skills that have taken place in previous sessions. The group will be voluntary because the members have to want to manage their symptoms and educate themselves on BD; if they do not want to change or they are forced to come they will not benefit from the group.

The goals of the group are to educate the men about BD, it's treatment, progress and difficulties; to promote acceptance of BD and reduce the associated stigma surrounding it; to develop an active role of the members in their treatment; to maximize adherence to treatment, especially to pharmacological regimens; to develop strategies for self-monitoring of symptoms, to help solve problems and stress factors that can cause a BD episode to happen; to build skills to deal with cognitive, affective, and behavioral factors associated with mood changes (Abreu, 2016).

Membership & Recruitment

For potential members to join the group they have to meet the eligibility criteria. The eligibility criteria for the BD group is they must be an African American man between the ages of 22 to 60 years. They must have a diagnosis of BD that aligns with the DSM-IV for BD I or II and has experienced at least one episode of hypomania, mania, or depression over the previous 12 months. Additionally, they must have taken mood-stabilizing medication for a minimum of one month before therapy (Costa et al., 2012).

Although potential members may meet the eligibility requirements there will be exclusion criteria. Exclusion criteria are as follows: people who have a low IQ, clients who have a severe psychiatric disorder that affects their professional, social, and personal life, those who have a severe dependence on drugs, and those who have a severe physical illness (Costa et al., 2012).

There will be 8 to 12 members in the group. Most of the literature that was reviewed had between 5 and 15 members. The reason I chose 8-12 members was because the therapist and group members will be able to know each other on a personal level, the group will know how the group operates and functions. Having a small group allows clients to be involved and participate more, rules that are set in place are adhered to better, group members will want to disclose things about themselves and confront each other more on different topics. Having a smaller group also allows the facilitators to easily manage and identify issues that may need to be addressed during each of the group phases.

The potential types of diversity among group members would be class, religion, and income. When members are in a group, class, religion, and income could be an issue during the

beginning phase because that's where most group members are trying to get a feel for the other members and group facilitators. During the beginning phase the group of men will feel more comfortable if there is one other person that is of the same class, religion, and income as them (Sweier, 2020). Once the group members have worked together for a while and entered the working phase, these potential diversities will slowly dissolve and new roles for members will be established, goals will be set, and obstacles will come about.

Obstacles during the working phase for class, religion, and income may not be a topic discussed when it relates to the BD group but if disclosed by a group member this could be a sensitive topic that would come in the form of resistance (Shulman, 2016). For example, religion may play a factor as to taking medication. The psychologist would educate BD members on different medications that could be needed and the side effects for each. When the member of a different religion voices their opinion, other members might forget the rules that were established and start conflict between members of different religions or who are agnostic and want to belittle the person. This will result in broken boundaries and confidentiality.

Income/class could be another obstacle. The reason for this is because some may be able to afford the help that they need in the group whereas others may not. For example, as the group moves toward the working stage and clients are starting to self-disclose more about their life and issues when dealing with BD the therapist may come to wonder how to help them as a group with regards to income/class. Especially when some members voice that they have individual therapy alongside group and are able to get medications whereas some of the group members only have group to help support them.

When recruiting members, I have to take in consideration the ethics when looking for members. Members could have heard about the group through their individual therapist, primary care doctor, psychologist, psychiatrist, family members, friends, or social media. The clients would voluntarily come to our group and be screened before entering the group. When they come to the group, three main ethical considerations are closely monitored: informed consent, confidentiality, and identity.

Informed Consent is where the facilitators provide the client with a clear structure of the purpose and risk of the group. If the client is willing to participate then he will have to sign an informed consent form. If he is not willing to participate or is not a good fit the facilitators will provide alternative services for the client (NASW, 2017). This informed consent form will address the rules and guidelines about privacy for themselves and group members as well as statements on confidentiality.

Confidentiality within the group is very crucial. Confidentiality is the bridge to building therapeutic alliance and group cohesion. When facilitators model confidentiality in front of the group, the group will more likely do the same. Facilitators can model confidentiality by not disclosing information about a client to the group, by having guidelines and rules for the group that help maintain confidentiality within the group, and finally showing mutual respect to the person who is self-disclosing personal information.

Identity comes through the form of connectivity within the group structure this is known as the group as a whole or group cohesion (Shulman, 2016). The group facilitators will identify the group participants' rights, compatibility for the group, and if the group is an appropriate fit for the client. As the members in the group start to become cohesive, the group will then start to form

into a group as a whole. This is where the group knows how the group operates and is able to go deeper into the process of learning about BD as well as establish roles to members.

The group will be co-led by a therapist and a psychologist. I chose two because one can be the recorder of what's happening in the group will the other leads and they can switch off each week. Having two people with similar backgrounds in the field but different approaches will help bring more participation to the group. As the psychologist and therapist work together, they will need to have various skills in order to engage the group members to participate in the group. First the facilitator must be able to help lead people through the process towards agreed-upon goals in a manner that encourages participation, ownership, and creativity by all those involved. As a facilitator the person(s) will take on many different roles (i.e. enabler, broker, empowerer, negotiator, educator, initiator, coordinator, researcher, and public speaker) (Sweier, 2020). These different roles will come into play at different times. For example, the educator role will present itself during the BD group by facilitators educating the members on the symptoms of BD, managing of BD, and coping skills to help manage their symptoms of BD. Other skills that facilitators will need are to be able to not take things personally, be vulnerable with their group when necessary, be a good listener, be empathetic, and be able to not take sides.

Group Readiness

The group will show that they're ready to participate by taking the Group Selection Questionnaire (GSR) (Burlingame et al., 2011), and having pre-group interviews (Swartz & Swanson, 2014). Before clients can be entered into the group, they will be screened to make sure they are a good fit for the group and that their goals align or are similar with the group's goals. The screening will continue to take place for four weeks after the initiation into the group to make sure clients are getting the help they need. The GSR will be a self-report questionnaire that is used to see members' expectancy and participation style within group therapy. Some questions on the GSR would be how are emotions when it comes to group settings, are you confrontational, what do you expect to gain from this group. Higher scores on the GSR result in lower expectancy and less participation in group therapy whereas lower scores on the GSR result in higher expectancy and higher participation (Burlingame et al., 2011).

Pre-group interviews are where facilitators and potential participants are able to discuss individual and group goals and determine if the group would be appropriate for the participant (Swartz & Swanson, 2014). The pre-group interviews would be done in person and would cover where the group will be held, the time of the group, who the facilitators will be, if there's parking and how to access it, group start date and how many sessions the group will be, and what the group structure and process will be. In the pre-group interview it will also be important to address questions related to disclosure, confidentiality, safety, and perpetration within the group and outside of the group.

Group Intervention

The African American BD group will meet once a week for 21 sessions from 7pm-8:30pm at a counseling center in Macomb, MI. In the beginning stage the potential group dynamics are where the facilitators will establish expectations of what the group will be like. These expectations include trust, roles, and goals. In this stage group members will make rules and guidelines for the group to follow. Confidentiality and conflict need to be addressed immediately.

Also, any culture concerns (i.e. religion) must be dealt with. The therapist and psychologist are there to explain the process and to support each member when dealing with confrontation. The group members must be willing to participate and be involved. Once everything has been established in the beginning stage the group will then move towards the working stage.

In the working stage, the group will start to feel more comfortable enough to get into the deeper issues the group was designed for. This stage follows the beginning stage and helps members be able to explore their thoughts and emotions that could have been triggered by another member's actions or words (Shulman, 2016). The therapist and psychologist will guide the group through this process using techniques and challenges that allow the members to confront each other. During this stage group members must be honest about their feelings and not afraid to speak their mind. They should not feel as though they are being judged or criticized and if they feel that they are, the therapist and psychologist will address these issues if the group members don't know how to address it themselves (Shulman, 2016).

In the working phase the therapist and psychologist will start to implement psychoeducation and cognitive behavioral therapy (CBT). The psychoeducation portion allows facilitators to educate the group on understanding BD and what it is (i.e. symptoms and treatments), provide information about medication adherence through resources and pamphlets, developing approaches to detect new episodes (i.e. symptom log tracker), identifying BD coping strategies (i.e. yoga, stress management) that will help them throughout life.

In the CBT portion there will be skills-based treatment and structured exercises such as thought records, mood diaries, and activity scheduling (Swartz & Swanson, 2014). Having an activity schedule will help BD patients develop a routine that will make managing symptoms easier (i.e. scheduling thought recording or mood diaries at a certain time of day). CBT helps members focus on automatic negative thoughts, distorted thinking, and maladaptive schema, and use exercises to detect new episodes or symptoms that appear with BD (Costa et al, 2012).

When the psychologist and the therapist start to implement the psychoeducation and CBT activities the group members will start to show themselves through informal roles. In this section of the paper I will address three informal roles: scapegoat, quiet member, and gatekeeper.

The first role is the scapegoat member. The scapegoat member is a member who feels attacked, verbally or physically, by other members (Shulman, 2016). Other members will project their own negative feelings about themselves onto the scapegoat member. The scapegoat behaviors can lead to aggression, hostility, and frustration within the group. Though the group functions as a whole each group has individual members. Individual members come in with a set of different issues that could be plaguing their minds at the time of group session. An example would be a member could direct their negative feelings (i.e insecurity, anger, anxiety) onto the quiet member because the member never talks in a group. The reason this could come about is because the member may feel the quiet member is judging them when in reality the quiet member could be reflecting or listening in on what the group has to say.

The second role is the quiet member. The quiet member is someone who sits in the group and does minimal or no talking at all. The issues that could arise when a member is quiet is that other group members can feel that the quiet member is judging them, does not relate to the group, or that others in the group are too talkative (Shulman, 2016). The facilitators can also become uncomfortable when a group member is too quiet. The facilitators may doubt their

abilities as reaching the group member when the group member is too quiet and may see the group member as not wanting to be involved in the group. The facilitators should try to build therapeutic alliances by allowing silence and looking at nonverbal cues to see what the member could be thinking or if the member is involved in the group.

The third role is the gatekeeper member. The gatekeeper is someone who attempts to keep the group communication lines open. The gatekeeper encourages and facilitates interactions from those members who are usually quiet (Shulman, 2016). They also divert the attention to another topic or make a distraction when the group discussion gets too personal or difficult making it harder for the group to progress.

The overall goals of the African American group are to help members become educated about BD, manage their symptoms, and be able to function in everyday life with the help of shown techniques by facilitators. Facilitators and group members will be able to form a group cohesiveness with the rules and goals that are established at the beginning stage of the group and be able to implement goals and treatment plans during the working stage of the group. As a result, the group members will be more aware about BD, have more knowledge on emotional regulation of their BD symptoms, and know what being in a support group is like and hopefully acknowledge that the group worked for their needs.

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