Small Group Delivery

Personal Improvement Plan · 12-Month Timeline

Timeline Mapping

CONTENTS

- Part 1 · Getting started
- Part 2 · Phase I · Group Documentation
- Part 3 · Phase II · Patient Rapport in Group
- Part 4 · Phase III · Establishing Trust & Safety
- Part 5 · Phase IV · Group Transitions
- Part 6 · Phase V · Keeping Groups SUD-Focused
- Part 7 · Phase VI · Group Cohesion
- Part 8 · Phase VII · Navigating Personalities
- Part 9 · Phase VIII · Boundaries in Group
- Part 10 · Phase IX · Challenging Cognitive Distortions

© The Recovery Files

Part 1 · Getting started

Small Group Delivery

Personal Improvement Plan · 12-Month Timeline

The Recovery Files · SUD Clinical Excellence

This tool guides SUD clinicians through a structured, 12-month improvement plan across 9 group facilitation competency domains — from documentation and rapport to cognitive distortion work and boundary management.

Let's personalize your plan. The more honest and specific, the more useful this becomes.

Your Name / Initials

e.g., T. Reyes, CADC-I

Your Role & Credential

e.g., Group Counselor, Case Manager

Clinical Setting

e.g., Residential, IOP, First Responder Program

Plan Start Date

e.g., January 2025

Supervisor / Mentor (optional)

e.g., S. Moran

© The Recovery Files

Part 2 · Phase I · Group Documentation

Domain 1 of 9

Group Documentation

"What happens in the group must live in the chart — with clinical precision, not just attendance records."

Group documentation in substance use disorder treatment is frequently an afterthought — a checkbox confirming the group happened. But a well-written group progress note captures clinical reasoning, member participation, therapeutic themes, and individual response to the group experience. It communicates continuity of care to the entire treatment team and protects both clients and clinicians from liability.

Overview

Why This Matters in SUD Group Work

Payers, accreditation bodies, and licensing boards scrutinize group documentation closely. More critically, when a client's counselor picks up that chart, your group notes should tell a clinical story — not just confirm presence. Documentation of group work is also one of the most powerful tools for tracking individual progress within the group context over time.

Domain Goals

1. Write group progress notes that capture both group-level dynamics and individual member responses

2. Document clinical themes, interventions used, and member reactions with specificity

3. Use person-centered, recovery-oriented, and non-stigmatizing language in all group records

4. Track member engagement, affect, participation level, and behavioral observations accurately

5. Complete group notes within required timeframes — not at the end of the week from memory

6. Capture teachable moments, cognitive distortions addressed, and evidence of skill acquisition

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Group Documentation?

Reflection

Clinical Reflection Prompts — Group Documentation

0% of prompts addressed.

© The Recovery Files

1. Current Practice

Read your last five group progress notes. Are they clinical documents or attendance records? What is missing that a treatment team member would genuinely need to know?
The gap between what happened and what you wrote IS the documentation problem.

Your reflection, observations, or coaching notes...

2. Individual vs. Group

How do you balance documenting group-level themes versus individual member responses? Do your notes capture both, or do they default to one?
Both levels of documentation are clinically required and ethically necessary.

Your reflection, observations, or coaching notes...

3. Clinical Language

Scan your recent group notes for deficit-based or stigmatizing language. What phrases would you want to rewrite? What person-centered alternative would you use?
Every client should be able to read their own chart without feeling judged.

Your reflection, observations, or coaching notes...

4. Timeliness

How long after a group session do you typically complete documentation? What gets in the way of completing it immediately? What is the clinical risk of delayed documentation?
Memory fades fast — the clinical detail that felt obvious at 2pm is gone by 5pm.

Your reflection, observations, or coaching notes...

5. Improvement Goal

What is one specific, measurable change you could make to your group documentation practice in the next 30 days? How will you know it improved?
One real change beats five intentions every time.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Group Documentation

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Audit 10 recent group notes against a quality standard; identify 3 specific gaps

What actually happened at the 30 days mark?

2. 60 days

Implement a group note template; sustain within-30-minute completion for 4 straight weeks

© The Recovery Files

What actually happened at the 60 days mark?

3. 90 days

Supervisor reviews and affirms measurable improvement in clinical depth and language quality

What actually happened at the 90 days mark?

4. 6 months

Group notes consistently reflect both group-level and individual-level clinical observations

What actually happened at the 6 months mark?

5. 12 months

Considered a documentation resource by peers; notes reflect sophisticated clinical reasoning

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Group Documentation

0% implemented. Check off each as you work on it.

Build a group note template with clinical prompts: theme, interventions, notable moments, individual observations, and plan

Write notes within 30 minutes of group ending — before your next task displaces the memory

Include at least one specific clinical observation per group member per session in your notes

Review your notes monthly against a self-created quality rubric: clinical depth, language, completeness

Ask your supervisor to review two group notes per month and give structured feedback

Practice the 'So What?' test: after every sentence, ask 'So what does this mean clinically?'

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 3 · Phase II · Patient Rapport in Group

Domain 2 of 9

Patient Rapport in Group

"In a group, you are building a relationship with every person in the room simultaneously — including the ones who look like they don't want one."

Rapport in a group setting is qualitatively different from individual rapport. You are not just building a relationship with each group member — you are building a relationship with the group as a whole, while modeling the kind of relational safety that allows group members to build rapport with each other. In SUD treatment, group members arrive carrying shame, distrust of authority, and often coercion.

Overview

Why This Matters in SUD Group Work

Research consistently shows that perceived group climate — particularly safety, belonging, and being valued — is the strongest predictor of group treatment outcomes in SUD. Group members do not engage, disclose, or risk when they do not feel genuinely seen by the facilitator.

Domain Goals

1. Develop individualized, genuine connections with each group member before expecting participation

2. Build rapport that is warm, boundaried, and consistent — not performance-based or conditional

3. Learn to read non-verbal communication in group and respond to it directly and skillfully

4. Create a group climate where every member feels equally valued — including the difficult ones

5. Practice using members' names and specific details they have shared to communicate genuine attention

6. Develop skills for bringing quiet members in without spotlighting or shaming them

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Patient Rapport in Group?

Reflection

Clinical Reflection Prompts — Patient Rapport in Group

0% of prompts addressed.

© The Recovery Files

1. Self-Assessment

If each member of your current group rated how valued, seen, and respected they feel by you personally, what would the range of scores look like? Who would score lowest, and why?
Differential rapport is a group facilitation problem — every member deserves genuine connection.

Your reflection, observations, or coaching notes...

2. Non-Verbal Awareness

During your last group, describe the body language of the members who were most disengaged. What were they communicating? How did you respond — or not respond — to those signals?
Non-verbal communication in group is constant and clinical — reading it is a skill.

Your reflection, observations, or coaching notes...

3. Difficult Members

Is there a current group member you find it hardest to connect with? What is your honest reaction to them? What would it take to build genuine rapport with that specific person?
The member who is hardest to like often needs rapport the most.

Your reflection, observations, or coaching notes...

4. Using Names

How consistently do you use group members' names during session? Do you know something specific and meaningful about each person's story, values, or goals that you actively reference?
A person's name is the sweetest sound in any language — remembering what they told you last week is even sweeter.

Your reflection, observations, or coaching notes...

5. Group Climate

What is the emotional temperature of your group? Does it feel safe enough for members to share real things, make mistakes, and disagree respectfully? What would you change about the climate you are currently co-creating?
Group climate is a co-creation — you are always its largest contributor.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Patient Rapport in Group

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Create a brief member-connection log; begin tracking names, details, and rapport observations

What actually happened at the 30 days mark?

2. 60 days

© The Recovery Files

Implement a structured pre-group greeting routine; reduce cold openings to zero

What actually happened at the 60 days mark?

3. 90 days

Supervisor observes and gives feedback specifically on differential rapport across members

What actually happened at the 90 days mark?

4. 6 months

Group climate assessment shows measurable improvement in perceived safety and belonging

What actually happened at the 6 months mark?

5. 12 months

Can articulate and demonstrate a personal rapport-building philosophy in group settings

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Patient Rapport in Group

0% implemented. Check off each as you work on it.

Greet each group member individually by name before session begins — in the hall, not just at the door

Keep a brief private note on each member: one meaningful thing they shared, one strength you observe

Practice using genuine, specific affirmations — not generic praise — at least once per member per session

Develop a group check-in structure that gives every voice equal space in the first five minutes

After group, spend two minutes reflecting: who did you connect with least today, and what is your plan?

Study MI's OARS — particularly Affirmations — as a relational tool, not just a technique

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 4 · Phase III · Establishing Trust & Safety

Domain 3 of 9

Establishing Trust & Safety

"Trust in a group is not given — it is built, tested, broken, and repaired. Your job is to stay steady through all four."

Psychological safety is the foundation on which all group therapeutic work is built. Without it, group members perform recovery rather than practicing it. In SUD groups, trust is especially fragile because many members have been repeatedly failed by authority, betrayed by people they trusted, and shamed in clinical settings.

Overview

Why This Matters in SUD Group Work

Amy Edmondson's research on psychological safety shows that it is the single most powerful variable in whether a group produces its best work — or plays it safe. In SUD treatment, 'playing it safe' means relapse. Trust is a treatment outcome variable, not just a nicety.

Domain Goals

1. Establish clear, consistent, and collaboratively developed group norms in every group

2. Model the vulnerability and honesty you are asking of group members

3. Maintain absolute consistency between what you say and what you do — every single session

4. Develop skills for naming ruptures in group trust quickly, directly, and non-defensively

5. Create rituals of safety — opening, closing, and confidentiality practices that are unwavering

6. Address trust-threatening behaviors immediately and skillfully

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Establishing Trust & Safety?

Reflection

Clinical Reflection Prompts — Establishing Trust & Safety

0% of prompts addressed.

1. Current Safety Level

© The Recovery Files

On a scale of 1–10, how psychologically safe is your current group? What evidence supports that number? What would need to change to raise it by two points?

Safety is measurable — it shows up in disclosure depth, risk-taking, and honest disagreement.

Your reflection, observations, or coaching notes...

2. Norm-Setting

How did the norms in your current group get established? Were they co-created with members, or handed down? Do members own them? Can they recite them?

Norms members helped create are norms members will actually follow.

Your reflection, observations, or coaching notes...

3. Modeling Vulnerability

In what ways do you model the openness and honesty you are asking of group members? Or do you hold yourself to a different standard — always the expert, never the learner?

You cannot ask for vulnerability you are not willing to practice yourself.

Your reflection, observations, or coaching notes...

4. Trust Ruptures

Describe a time when trust was broken in a group you facilitated. How did you respond? In retrospect, what would have been more skillful?

Trust ruptures are inevitable. How you repair them defines your facilitation integrity.

Your reflection, observations, or coaching notes...

5. Confidentiality

How do you address confidentiality — not just as a legal disclaimer, but as a living agreement that the group actively maintains? What happens when it is violated?

Confidentiality is the floor of group safety. Without it, everything else is performance.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Establishing Trust & Safety

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Audit your current group norms — were they co-created? Do members know them? Revise as needed

What actually happened at the 30 days mark?

2. 60 days

Implement a consistent opening and closing ritual; track member engagement across 8 sessions

What actually happened at the 60 days mark?

3. 90 days

Address one trust-rupture or safety-threatening behavior skillfully; document and debrief

What actually happened at the 90 days mark?

4. 6 months

Members demonstrate deeper self-disclosure and risk-taking compared to group start

What actually happened at the 6 months mark?

5. 12 months

Can teach another clinician how to build psychological safety in SUD groups from scratch

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Establishing Trust & Safety

0% implemented. Check off each as you work on it.

Open every new group with a collaborative norm-setting process — not a handout, a conversation

Revisit group norms at the start of each month and whenever a new member joins

Practice naming the emotional temperature of the group out loud: 'I'm noticing something quiet today...'

Develop a clear, practiced response to confidentiality violations — a script you can deliver calmly

Create a closing ritual that reinforces safety: gratitude round, one word check-out, or bridge statement

Read Yalom's 'Instillation of Hope' and 'Universality' chapters — the trust-builders of group therapy

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 5 · Phase IV · Group Transitions

Domain 4 of 9

Group Transitions

"How you open the group and how you close it are the most underutilized clinical tools in the room."

Group transitions — how you open, close, move between topics, handle latecomers and early leavers, bring a new member in and say goodbye to one who is leaving — are rarely taught and almost never practiced. Yet they are among the most clinically significant moments in any group session.

Overview

Why This Matters in SUD Group Work

Transitions are moments of vulnerability for group members. Openings set the emotional contract for the entire session. Closings regulate the nervous system before members return to their lives. Mastering transitions is mastering the architecture of healing.

Domain Goals

1. Develop a consistent, intentional group opening that sets tone, establishes safety, and activates engagement

2. Master the closing ritual — summarizing, bridging, regulating, and sending members out with hope

3. Build skills for mid-session transitions: moving between topics without losing momentum or members

4. Develop a new-member integration protocol that protects existing group cohesion

5. Learn to handle latecomers and early departures without disrupting group process

6. Practice the therapeutic use of silence and pacing as transition tools

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Group Transitions?

Reflection

Clinical Reflection Prompts — Group Transitions

0% of prompts addressed.

© The Recovery Files

1. Opening Practice

Walk me through exactly how you open a group session. What do you say first? What is the clinical intention behind your opening? What are you trying to activate in the room?
An intentional opening is a clinical intervention — not a warm-up formality.

Your reflection, observations, or coaching notes...

2. Closing Practice

How do you close group? Is it rushed or intentional? Do members leave regulated or dysregulated? Do you build a bridge to the next session or just end when time runs out?
A 5-minute closing done well is worth 20 minutes of content.

Your reflection, observations, or coaching notes...

3. New Members

When a new member joins an existing group, how do you integrate them without fragmenting group cohesion or putting them on the spot? What is your protocol?
New member integration is a group preservation skill — do it poorly and you set back weeks of work.

Your reflection, observations, or coaching notes...

4. Managing Disruptions

How do you handle latecomers? Early leavers? Members who are clearly distracted? How do you re-center the group without shaming the individual?
Disruptions are clinical moments, not inconveniences — they reveal group dynamics.

Your reflection, observations, or coaching notes...

5. Topic Transitions

When the group goes off-topic or the energy shifts significantly, how do you redirect without shutting down the person who derailed the thread? What is your transition language?
Redirection is a craft — it can feel like a gift or like a slap, depending on how it's done.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Group Transitions

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Script your standard opening and closing; practice them identically for 8 sessions; gather member feedback

What actually happened at the 30 days mark?

2. 60 days

© The Recovery Files

Develop a written new-member integration protocol and use it with the next new group member

What actually happened at the 60 days mark?

3. 90 days

Supervisor observes specifically for transition quality; feedback integrated into practice

What actually happened at the 90 days mark?

4. 6 months

Group members can describe what opening and closing group feels like — it is a safe, known ritual

What actually happened at the 6 months mark?

5. 12 months

Transitions are seamless, clinical, and distinctive — they are part of your facilitation signature

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Group Transitions

0% implemented. Check off each as you work on it.

Script and practice 3 different group openings — check-in round, breathing anchor, topic introduction — and rotate intentionally

Develop a 5-minute closing script that includes: summary, one-word check-out, bridge to next session, and a hope statement

Create a 'New Member Welcome Protocol' — a document for yourself that standardizes how you integrate new members

Practice the phrase: 'I want to honor what [name] just shared, and I also want to bring us back to...'

Build in 5 minutes of silence practice after an emotionally heavy group segment

Study how master group therapists handle transitions on recorded sessions — SAMHSA and ATTC have free video libraries

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

© The Recovery Files

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 6 · Phase V · Keeping Groups SUD-Focused

Domain 5 of 9

Keeping Groups SUD-Focused

"In a SUD group, everything eventually leads back to the substance — your job is to build that road, not just wait for it to appear."

One of the most common pitfalls in SUD group facilitation is drift — the group gradually moves away from its therapeutic purpose into general venting, social chat, life advice, or relationship drama. A skilled SUD group facilitator knows how to honor the person's whole story while consistently returning to the clinical purpose.

Overview

Why This Matters in SUD Group Work

SUD treatment groups are clinical interventions, not support circles. Every minute of group time is precious, payer-funded, and potentially life-changing. The facilitator who allows persistent off-topic groups is not being kind — they are being negligent.

Domain Goals

1. Develop fluency in linking any life content back to addiction, recovery, or SUD treatment goals

2. Learn to validate the whole person's story while maintaining clinical group focus

3. Build skills for redirecting off-topic drift without shaming the member who brought the drift

4. Practice the SUD-to-life connection — helping members see how addiction shows up in every domain

5. Develop a repertoire of focusing statements that redirect without shutting down

6. Distinguish between therapeutic exploration and off-topic avoidance — and name it when necessary

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Keeping Groups SUD-Focused?

Reflection

Clinical Reflection Prompts — Keeping Groups SUD-Focused

0% of prompts addressed.

1. Drift Awareness

In your last three groups, how much of the total group time was genuinely focused on substance use disorder, recovery, or treatment-specific content? What drifted away from that focus, and why did you let it?

Honest time-audit is the first intervention.

Your reflection, observations, or coaching notes...

2. Linking Skills

How skilled are you at connecting general life content to SUD themes? Can you take a member talking about a conflict with their boss and link it back to denial, triggers, or recovery capital within 30 seconds?

The link IS the clinical intervention — it shows members that recovery touches everything.

Your reflection, observations, or coaching notes...

3. Facilitator Anxiety

Are there SUD topics you tend to avoid in group — relapse, cravings, drug dreams, controlled use thinking, grief over the substance? What happens in you when those topics come up?

Facilitator avoidance is the most common cause of group drift.

Your reflection, observations, or coaching notes...

4. Member Avoidance

Which members in your current group most consistently steer the conversation away from their own substance use? What do you think is driving that? How do you respond to it?

Off-topic is sometimes on-topic — it is avoidance of the very thing that needs addressing.

Your reflection, observations, or coaching notes...

5. Refocusing Language

What specific language do you use to redirect a group back to its SUD focus without dismissing what was just shared? Write out three phrases you could use fluently in the moment.

Having the words ready means you can use them — without them, you hesitate and drift continues.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Keeping Groups SUD-Focused

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Begin a post-group time-on-topic audit; establish a baseline SUD-focus percentage

What actually happened at the 30 days mark?

2. 60 days

© The Recovery Files

Develop and implement a standard session focus statement at the start of every group

What actually happened at the 60 days mark?

3. 90 days

Practice 10 specific linking statements; track their use across 8 group sessions

What actually happened at the 90 days mark?

4. 6 months

SUD-focus audit shows consistent improvement; drift is identified and redirected within 2–3 minutes

What actually happened at the 6 months mark?

5. 12 months

Groups are consistently purposeful, focused, and therapeutically productive per SUD treatment goals

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Keeping Groups SUD-Focused

0% implemented. Check off each as you work on it.

Practice the linking statement: 'I hear you on [what they shared] — and I'm curious how that connects to your recovery...' — use it deliberately for two weeks

Develop a 'SUD Compass' — a one-page guide of your group's stated treatment goals you can reference when drift occurs

Build a repertoire of SUD-specific discussion anchors: triggers, urges, high-risk situations, recovery capital, relapse warning signs

When a member goes significantly off-topic, practice honoring it and bridging: 'That matters. Let's come back to that. Right now I want us to stay with...'

At the start of each group, explicitly name the SUD-focused intention for the session — make the purpose visible

Conduct a self-audit: after each group, estimate the percentage of time spent on SUD-relevant content and track it monthly

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

© The Recovery Files

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 7 · Phase VI · Group Cohesion

Domain 6 of 9

Group Cohesion

"Cohesion is not when everyone gets along. It is when the group can do hard things together — and trust that they will survive it."

Group cohesion is the therapeutic glue of SUD treatment groups. It is the sense of 'we-ness' — shared identity, mutual investment, and interpersonal trust — that makes the group more than the sum of its parts. Cohesive groups have better attendance, deeper disclosures, greater peer accountability, and dramatically better outcomes.

Overview

Why This Matters in SUD Group Work

Yalom identified cohesion as the most important therapeutic factor in group psychotherapy — the equivalent of the therapeutic alliance in individual therapy. In SUD groups, cohesion is what makes one member's relapse someone else's learning, and one member's breakthrough everyone's hope.

Domain Goals

1. Develop skills for cultivating universality — the powerful discovery that 'I am not alone in this'

2. Learn to weave individual member stories into shared group narratives and themes

3. Build cohesion-promoting rituals: shared language, inside history, collective milestones

4. Develop skills for managing cohesion-threatening events: conflict, dropout, new members, relapse disclosure

5. Teach members to speak to each other — not just through the facilitator

6. Learn to name and celebrate group growth moments explicitly and specifically

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Group Cohesion?

Reflection

Clinical Reflection Prompts — Group Cohesion

0% of prompts addressed.

1. Current Cohesion

© The Recovery Files

How would you describe the cohesion level of your current group? Do members feel a genuine sense of 'we'? What is the evidence for your assessment?

Cohesion is observable — it shows up in how members talk to and about each other.

Your reflection, observations, or coaching notes...

2. Universality

How often do you create universality moments — where a member's disclosure is reflected back as something the group shares? What specific techniques do you use to build those moments?

'Who else has experienced this?' is one of the most powerful sentences in group facilitation.

Your reflection, observations, or coaching notes...

3. Member-to-Member

What percentage of member communication in your group flows through you versus directly between members? What could you do differently to reduce your role as traffic controller?

When members talk to each other, cohesion builds. When they talk to you, you are a bottleneck.

Your reflection, observations, or coaching notes...

4. Cohesion Threats

What events in your current or recent groups have threatened cohesion — conflict, a difficult disclosure, a relapse, a dropout? How did you respond? What was the effect on the group?

How you handle cohesion-threatening moments determines whether cohesion survives them.

Your reflection, observations, or coaching notes...

5. Celebrating Growth

How do you celebrate group milestones — a member's anniversary, a group breakthrough, a hard conversation survived? Do you name those moments explicitly, or let them pass unmarked?

What you celebrate becomes part of the group's identity and shared history.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Group Cohesion

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Assess current group cohesion using a simple 1–10 scale with the group; baseline established

What actually happened at the 30 days mark?

2. 60 days

Implement one new cohesion-building structure per session; track member-to-member communication ratio

© The Recovery Files

What actually happened at the 60 days mark?

3. 90 days

Group can identify shared history, shared language, and shared milestones when asked

What actually happened at the 90 days mark?

4. 6 months

Cohesion is observable in attendance consistency, depth of disclosure, and peer support behaviors

What actually happened at the 6 months mark?

5. 12 months

Group functions as a genuine therapeutic community; facilitation is more catalytic than directive

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Group Cohesion

0% implemented. Check off each as you work on it.

Practice universality explicitly: after a disclosure, scan the room and ask 'Who else knows this feeling?' before moving on

Develop a group timeline — a visible, shared record of where the group has been and what it has survived together

Teach members reflective listening: 'Before responding, can you reflect back what you just heard [name] say?'

Create a shared group vocabulary: allow the group to name their collective experiences in their own language

When a member relapses, use it as a cohesion moment — bring the group in rather than isolating the individual

Celebrate milestones explicitly: sobriety birthdays, hard conversations, new member integrations, group anniversaries

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

© The Recovery Files

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 8 · Phase VII · Navigating Personalities

Domain 7 of 9

Navigating Personalities

"The dominant member, the silent member, the rescuer, the skeptic — they are not problems to manage. They are the curriculum."

Every SUD group will have its collection of challenging personalities. An experienced facilitator sees them as the group's most valuable clinical material — and as mirrors for the other members' own patterns. Personality dynamics in group directly replicate the interpersonal patterns that sustain addiction.

Overview

Why This Matters in SUD Group Work

When the facilitator skillfully works with these dynamics rather than managing them away, group becomes a live laboratory for the very behavioral changes recovery requires.

Domain Goals

1. Develop a clinical framework for understanding common group personality archetypes in SUD populations

2. Build skills for working with dominant members without silencing or shaming them

3. Develop techniques for gently activating silent and withdrawn members

4. Learn to use the rescuer dynamic therapeutically rather than suppressing it

5. Build skills for managing the skeptic and the resister without power struggles

6. Develop the ability to identify and name group dynamics in real time, to the group, as clinical material

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Navigating Personalities?

Reflection

Clinical Reflection Prompts — Navigating Personalities

0% of prompts addressed.

1. Dominant Members

Describe your current strategy for managing a group member who consistently dominates the airtime. Is it working? What does the rest of the group experience while you are managing this person?

How you handle the dominant member communicates your power model to the entire group.

Your reflection, observations, or coaching notes...

2. Silent Members

How do you bring in quiet members without spotlighting them, shaming them, or making them feel like a project? What is the clinical message you want to convey to a silent member?

Silence is communication — the question is what it is communicating and whether you are listening.

Your reflection, observations, or coaching notes...

3. The Rescuer

When one group member consistently jumps in to comfort, advise, or rescue another before they can sit with discomfort — how do you respond? What is the therapeutic cost of allowing it to continue?

Rescuing in group is practicing the same behavior that fuels codependency and enabling in recovery.

Your reflection, observations, or coaching notes...

4. The Skeptic

How do you handle the group member who openly doubts the value of group, challenges the treatment model, or voices cynicism that risks infecting other members?

The skeptic is often the most defended member — and the one with the most to gain from the group.

Your reflection, observations, or coaching notes...

5. Using Dynamics Therapeutically

Can you think of a recent group dynamic — a personality clash, a dominance pattern, a rescue sequence — that you could have named as group process and used as clinical material? What stopped you?

The moment you name the dynamic, you turn it into therapy.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Navigating Personalities

Click a milestone node to mark it complete. 0% complete.

1. 30 days

© The Recovery Files

Create a personality dynamics map for your current group; identify the archetype of each member

What actually happened at the 30 days mark?

2. 60 days

Practice one new intervention for each of the 3 most challenging dynamics in your group

What actually happened at the 60 days mark?

3. 90 days

Name group process aloud to the group at least once per session for 4 consecutive sessions

What actually happened at the 90 days mark?

4. 6 months

Dominant dynamics are consistently redirected; silent members are regularly and skillfully engaged

What actually happened at the 6 months mark?

5. 12 months

Group dynamics are fluently used as clinical material; personality patterns are therapeutic curriculum

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Navigating Personalities

0% implemented. Check off each as you work on it.

Study Yalom's personality archetypes in group: the monopolizer, the help-rejecting complainer, the schizoid, the boring patient — each has a clinical approach

Develop a repertoire of non-shaming redirects for dominant members: 'I want to make sure we hear from everyone — [name], let's hold that and come back to it'

Practice the 'invitation without pressure' for silent members: 'I've been noticing you sitting with this — no pressure, but I'd love to hear what's coming up for you'

When a rescue sequence occurs, name it directly to the group

Use the here-and-now: 'I want to name something happening in this room right now that connects to what we are all working on...'

Keep a private group process log — after each session, write one paragraph about the dynamics you observed

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

© The Recovery Files

Days 31–60

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 9 · Phase VIII · Boundaries in Group

Domain 8 of 9

Boundaries in Group

"A boundary without explanation is a wall. A boundary with clinical intention is a container that makes healing possible."

Boundaries in SUD group settings operate on multiple levels simultaneously: the facilitator's personal and professional boundaries, the group's norms around appropriate disclosure and interaction, and the boundaries between group members outside of group. Poor boundary management leads to enmeshment, enabling, trauma exposure without containment, and facilitator burnout.

Overview

Why This Matters in SUD Group Work

Many clients in SUD treatment have significant boundary dysfunction — the very relational patterns that sustained their addiction show up with full force in group. The facilitator who cannot model and maintain clear, warm, consistent boundaries is reinforcing the relational pathology they are supposed to be treating.

Domain Goals

1. Develop and consistently maintain clear professional boundaries in group settings

2. Build skills for naming and enforcing group norms around appropriate self-disclosure

3. Establish clear boundaries around out-of-group contact between members — and enforce them thoughtfully

4. Learn to hold the group's emotional boundaries — preventing trauma dumping without clinical containment

5. Develop skill in declining inappropriate group content kindly, firmly, and clinically

6. Model boundaried care — warmth and structure as partners, not opposites

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Boundaries in Group?

Reflection

Clinical Reflection Prompts — Boundaries in Group

0% of prompts addressed.

1. Your Own Boundaries

Where in your current group work do you find it hardest to maintain your professional boundaries? Do you over-disclose? Take on members' problems emotionally? Avoid confrontation to preserve the relationship?

Your boundary struggles in group are parallel process — the group will reflect them back.

Your reflection, observations, or coaching notes...

2. Disclosure Limits

How do you manage graphic or traumatic disclosures in group that could traumatize other members without the clinical containment of an individual session? What is your protocol?

Uncontained group disclosure can re-traumatize every person in the room.

Your reflection, observations, or coaching notes...

3. Out-of-Group Relationships

What are your expectations and rules around group members socializing, communicating, or forming relationships outside of group? How do you address dual relationships between members?

Outside relationships between members are not just policy issues — they are clinical ones.

Your reflection, observations, or coaching notes...

4. Enforcing Limits

When a group member crosses a boundary — toward you, toward another member, or toward the group norms — how do you address it in the moment? What is your language?

Silence in the face of boundary violations communicates that violations are acceptable.

Your reflection, observations, or coaching notes...

5. Warmth and Structure

Do you experience boundaries and warmth as opposites — as if being clear requires being cold? How would you define 'boundaried care' in your own words and clinical practice?

The most therapeutic relationship is warm AND structured — they are not in tension.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Boundaries in Group

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Draft or revise your group contract; review it with current group; identify any current boundary drift

What actually happened at the 30 days mark?

2. 60 days

Address the next boundary violation in the moment, to the group; document and debrief with supervisor

What actually happened at the 60 days mark?

3. 90 days

Supervisor observes your boundary practice; identify where structure and warmth are integrated vs. in tension

What actually happened at the 90 days mark?

4. 6 months

Zero unaddressed boundary violations in the past 90 days; group contract is a living document

What actually happened at the 6 months mark?

5. 12 months

Boundaries are experienced by group members as a safety structure, not a punitive one

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Boundaries in Group

0% implemented. Check off each as you work on it.

Develop a written 'Group Contract' that members sign — covering disclosure norms, out-of-group contact, confidentiality, and conduct expectations

Practice the boundary statement formula: 'I need to pause us there, because [clinical reason]. What I want to offer instead is...'

Address all boundary violations in the moment, to the group, not in private after — the group witnessed it and needs to see you respond

Develop a protocol for graphic trauma disclosure: acknowledge it, contain it, offer a 1:1 follow-up, and bring the group back

Review your own disclosure patterns monthly — are you sharing appropriate facilitator transparency?

Study DBT's concept of irreverence and validation as a model for holding warmth and structure simultaneously

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

© The Recovery Files

What am I building on? What will I practice?

Days 61–90

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files

Part 10 · Phase IX · Challenging Cognitive Distortions

Domain 9 of 9

Challenging Cognitive Distortions

"The thinking that got them to addiction will keep them there — unless you learn to challenge it skillfully, not confrontationally."

Cognitive distortions are the thinking errors that sustain addiction, justify continued use, minimize consequences, and sabotage recovery. In SUD groups, you will hear them constantly. A skilled SUD group facilitator learns to challenge cognitive distortions in a way that opens rather than closes the conversation.

Overview

Why This Matters in SUD Group Work

Aaron Beck's cognitive model shows that distorted thinking precedes relapse — long before the drink or drug, the cognitive distortion provides the permission. Challenging these patterns in group, in real time, with peer reflection, is one of the most powerful interventions in SUD treatment.

Domain Goals

1. Develop fluency in identifying the most common cognitive distortions in SUD populations

2. Learn to challenge distorted thinking with curiosity rather than confrontation

3. Build skills for using peer reality-testing in group as a more powerful tool than clinician challenge

4. Practice Motivational Interviewing's 'developing discrepancy' as a distortion intervention

5. Develop language for naming distortions without labeling or shaming the person holding them

6. Connect cognitive distortion work explicitly to relapse prevention and ongoing recovery planning

Self-Assessment

Rate your current competency honestly. Then set a realistic 12-month target.

Current Level (1–10) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 12-Month Target

What I Want to Improve

What honest gap do you want to close in Challenging Cognitive Distortions?

Reflection

Clinical Reflection Prompts — Challenging Cognitive Distortions

© The Recovery Files

0% of prompts addressed.

1. Recognizing Distortions

List the cognitive distortions you hear most commonly in your SUD groups. Which ones do you challenge? Which ones do you let slide? What determines which ones you engage with?

The distortions you let slide are the ones you may be colluding with.

Your reflection, observations, or coaching notes...

2. How You Challenge

Describe your current approach when a group member expresses a clear cognitive distortion — minimization, rationalization, externalizing blame, or all-or-nothing thinking. What do you say? What is the effect?

Confrontation increases defensiveness. Curiosity increases openness. Which are you practicing?

Your reflection, observations, or coaching notes...

3. Using the Group

When a member expresses a distortion, do you challenge it yourself or invite the group to respond? What is the difference in clinical impact?

Peer challenge is more powerful than clinician challenge — and harder to dismiss.

Your reflection, observations, or coaching notes...

4. Developing Discrepancy

How skilled are you at developing discrepancy — helping a member see the gap between their stated values and goals and their current behavior and thinking — without triggering shame or shutdown?

Discrepancy is the engine of motivation. Shame is the handbrake.

Your reflection, observations, or coaching notes...

5. Connecting to Relapse

How explicitly do you link cognitive distortions to relapse risk in group? Do members understand that their thinking patterns are relapse warning signs, not just bad habits?

Making the cognitive-relapse connection explicit is a clinical imperative in SUD treatment.

Your reflection, observations, or coaching notes...

Open Reflection Space

Anything else this domain is bringing up for you?

Timeline

12-Month Milestone Timeline — Challenging Cognitive Distortions

Click a milestone node to mark it complete. 0% complete.

1. 30 days

Create your SUD Distortion Dictionary; identify top 5 distortions in your current group

What actually happened at the 30 days mark?

© The Recovery Files

2. 60 days

Practice curiosity-first responses to distortions in group; shift away from confrontational challenge

What actually happened at the 60 days mark?

3. 90 days

Use peer reality-testing deliberately in 4 consecutive sessions; document member response

What actually happened at the 90 days mark?

4. 6 months

Members can identify cognitive distortions in themselves and peers using shared group language

What actually happened at the 6 months mark?

5. 12 months

Cognitive distortion work is seamlessly integrated into all group sessions; members use it as a relapse prevention tool

What actually happened at the 12 months mark?

Action Plan

Recommended Strategies — Challenging Cognitive Distortions

0% implemented. Check off each as you work on it.

Build a 'Distortion Dictionary' for your SUD population — the 10 most common thinking errors you hear, with your clinical response to each

Practice the MI curiosity question: 'Help me understand... when you say [distortion], what does that mean to you?' — before any challenge

Use the group as a reality-testing tool: 'I'd love to hear what others think about what [name] just shared about their using...'

Study the Socratic method as an alternative to confrontation — ask questions that lead to self-discovery

Connect each distortion explicitly to the relapse cycle: 'This kind of thinking, when we don't challenge it, is often the first step toward a relapse. Who has experienced that?'

Role-play distortion challenges in peer supervision or with your own supervisor — fluency requires practice outside the room

My 30 / 60 / 90-Day Action Steps

Next 30 Days

What specific action will I take this month?

Days 31–60

What am I building on? What will I practice?

Days 61–90

© The Recovery Files

What has changed? What feedback will I seek?

Accountability Plan

Who will help you stay accountable? How will you use supervision to grow in this domain?

© The Recovery Files