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Successfully Implementing a Group for Adult Children of Alcoholics and Adult Children of Parents With Mental Illness on a College Campus

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Because of their demographics, university counseling centers have an opportunity to reach both adult children of alcoholics and adult children of parents with mental illness who are at risk for poor psychosocial outcomes. This article presents a group intervention targeting these students. The authors describe the development and implementation of the Successful Survival group and considerations for clinical training. Also discussed are recommendations for future research, practice, and clinical training.

Keywords: group therapy, adult children of alcoholics, adult children of parents with mental illness

Research suggests that 17%–33% of all college students are adult children of alcoholics (ACOAs; Kelley et al., 2005). Compared with non-ACOAs, ACOAs are at risk for a number of psychosocial, academic, and occupational problems, including substance abuse, depressive and anxiety symptoms, low self-esteem, antisocial behavior, poor overall wellness, isolation, shame and guilt, and limited coping resources (Beesley & Stoltenberg, 2002; Hall, Bolen, & Webster, 1994; Hall & Webster, 2007; Harter, 2000). Researchers studying college-age ACOAs suggest that when compared with their non-ACOA peers, ACOAs struggle with greater irrational thinking and anxiety, leading to difficulty making decisions on majors and career paths (Skorupa & Agresti, 1998), as well as issues with romantic relationships, such as engaging in anxious/avoidant attachment styles and increased anxiety in relationships (Kelley et al., 2005).

While information on adult children of mentally ill parents (ACOMIs) is limited and dated, it is estimated that around 5 million children in the United States have a parent with serious mental illness (Nicholson, Biebel, Katz-Leavy, & Williams, 2004), and many ACOMIs face similar risk factors as ACOAs. Researchers working with this population have found that when compared with non-ACOMIs, ACOMIs have an increased level of work and marriage problems and lower overall functioning (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997), lower self-esteem and greater social avoidance (O. B. Williams & Corrigan, 1992), poor social adjustment (Jacob & Windle, 2000), and increased alcohol intake (Neff, 1994). Other negative outcomes for this population include isolation, guilt, and childhood neglect and abuse (Dunn, 1993); feelings of hatred toward mother and self, poor parenting skills, stigma, and low levels of social support (A. S. Williams, 1998); and difficulty accomplishing vocational or educational goals and maintaining healthy relationships (Stromwall & Robinson, 1998). Mowbray, Bybee, Oyserman,

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MacFarlane, and Bowersox (2006) found that roughly 54% of ACOMIs sampled experienced major problems in regard to psychological, substance, or legal areas.

Given these risk factors, ACOAs and ACOMIs (ACOAs/ACOMIs) may be likely to develop clinical or subclinical problems, which would benefit from psychological treatment. Given the high number of ACOAs/ACOMIs in the population, as well as high estimates of ACOAs in college populations, university counseling centers (UCCs) have a unique opportunity to address the needs of these individuals. Furthermore, the university experience presents new challenges, and when combined with the aforementioned risk factors, this suggests that the university years are ripe for intervention.

Literature and meta-analyses examining the effectiveness of group therapy indicate that group treatment, including psychoeducational support groups, is a highly effective method of treatment and is often just as or more effective than individual treatment (Burlingame, Fuhriman, & Mosier, 2003; Parcover, Dunton, Gehlert, & Mitchell, 2006; Toseland & Siporin, 1986; Yalom & Leszcz, 2005). Psychoeducational support groups are therapy groups that consist of key elements, including (a) a formal education component, (b) trained group leaders, (c) a fixed number of sessions or time limit, (d) closed and structured group format, and (e) focus on a particular theme (Brown, 2004; McInnis-Perry & Good, 2006). Process-oriented work, while included, is considered secondary to goals around increasing information, support, and coping skills (McInnis-Perry & Good, 2006). Psychoeducational support groups provide benefits that include reduced isolation, improved social skills, decreased psychopathology symptoms, social learning, increased social support, receipt and rehearsal of new information, improved decision making, enhanced coping mechanisms, and strengths-focused action and growth (Brown, 2004; Lukens & McFarlane, 2004; Mattanah, Brooks, Brand, Quimby, & Ayers, 2012; McFarlane, 2002; Steen, Bryan, & Day-Vines, 2011). Furthermore, psychoeducational support groups allow for increased efficiency and maximization of services (Steen et al., 2011), and the structured components are best suited for short-term, goal-oriented groups (Yalom & Leszcz, 2005).

Literature on psychoeducational support groups for ACOMIs is limited; more evidence exists for these groups being effective for ACOAs, although it is dated. Previous support groups have focused on normalizing, reducing shame, decreasing isolation and increasing belonging, improving emotion regulation and distress tolerance, alleviating anxiety, and enhancing self-care (Clark & Jette, 1991; Cooper & McCormack, 1992; McDermott & Winterowd, 1989; Ricelli, 1987; Treadway, 1991). In studies of university populations, researchers have found these groups to be highly effective, especially in reducing isolation, anger, shame, depression, and anxiety symptoms as well as by increasing insight and awareness (Clark & Jette, 1991; Cooper & McCormack, 1992; McDermott & Winterowd, 1989; Ricelli, 1987). Participants cited the most helpful components included feelings of universality and support, as well as didactic materials (Clark & Jette, 1991).

UCCs are burdened with treating an increasing number of students as well as students with more severe psychopathology than in previous years (Erdur-Baker, Aberson, Barrow, & Draper, 2006; Gabriel, 2010; Guess, 2008; Munsey, 2010; Smith et al., 2007). Group treatment modalities that can reach many

students with serious risk factors, such as ACOAs/ACOMIs, can help UCCs to meet this challenge by reducing counselor workload in other areas, such as individual therapy, crisis work, and triage. Indeed, literature indicates that psychoeducational support groups help members develop a host of skills that can be applied to areas outside the direct goals of the group, such as managing stress, anxiety, and depressive symptoms (Lukens & McFarlane, 2004; Steen et al., 2011; Yalom & Leszcz, 2005). Our experience indicates these groups also provide opportunities for clinical training, often a priority in UCCs, and enhancement of campus-wide support systems.

This article describes a psychoeducational support group for ACOAs/ACOMIs in a UCC setting. Through the group, we hoped to provide a supportive environment for the participants, allowing them to learn key skills and coping mechanisms through feedback and sharing of experiences.

Group Development

Group Structure

The 1.5-hour psychoeducational support group, Successful Survival, was developed by the first author and run in various settings before being modified for a midsized, Jesuit campus where it was led by both authors (first author as a staff psychologist and second author as a predoctoral intern). Although we did not conduct a formal needs assessment, several clients in our UCC identified as ACOAs/ACOMIs, either through self-identification or identification by a clinician. Given our UCC's 10-session limit for individual therapy, there were clear benefits to creating a psychoeducational support group that would allow many individuals to learn skills in a supportive environment of peers with similar backgrounds. Previous groups have included topics similar to ours and demonstrated effectiveness (Clark & Jette, 1991; Cooper & McCormack, 1992; McDermott & Winterowd, 1989; Ricelli, 1987). All three groups ran for 8 weeks to align with the 10-week quarter system. After the first quarter, this format was deemed to be successful based on group members' positive feedback (as reported in our clinic's informal student satisfaction surveys) and increased interest in the group by other students/clients. The group ran for the following 2 quarters, with a new group of students each quarter. Recruitment occurred in the first 2 weeks of the quarter for the fall, and in the quarters prior for winter and spring. Because the themes in the group repeated each quarter, students were not allowed to continue after completing a quarter.

The stated goals of the group, based on works by Black (1981, 1995), Woititz (1983, 1990), and Gravitz and Bowden (1985), were to (a) decrease feelings of isolation, shame, and guilt; (b) normalize processes and behaviors experienced and learned as a result of growing up in a chaotic, unstable, and/or unpredictable household; (c) convey that processes and behaviors that were adaptive for survival in family relationships or systems can be maladaptive in current relationships or systems; (d) improve self-awareness and self-care; (e) increase self-efficacy around managing difficult situations and emotions; (f) improve the ability to create and maintain adaptive boundaries and manage relationships with

identified family member(s); and (g) increase knowledge of psychoeducational topics and how they apply to family and self. All sessions began with a brief mindfulness meditation based on Thich Nhat Hanh's (1975) work to provide a technique for stress management, to improve distress tolerance, and to provide a ritual in which the members could improve focus and presence on the group experience. Groups with mindfulness components have demonstrated reduced symptoms of anxiety, depression, and academic distress long term in college students (Byrne, Bond, & London, 2013). After this meditation, members began check-ins, spending about 2 minutes sharing general updates, noting anything they wanted to explore further or were triggered by in the previous week, and asking for additional support from the group if needed. The psychoeducation activity followed, and lasted approximately 20 minutes.

The themes of each group (described in the following sections) were organized to address group goals. Themes initially centered on family-of-origin issues (family roles, codependency), then on issues of self and response patterns (mind–body relationship, all-or-nothing thinking, self-care), and finally on current and future relationships (rights, support networks). Handouts were provided to enhance learning of each week's theme. Debriefing about the activity and support for members ensued for the following group component. During this component, members explored how to apply skills or topics learned in the session to their lives, families, and relationships. Group leaders facilitated discussion to encourage group cohesion and address goals such as normalizing, decreasing isolation, and increasing self-awareness. Occasionally, group leaders made process comments and observations based on intergroup dynamics to further these goals. The last 5–10 minutes of the group were reserved for another mindfulness meditation to help ground members and reorient them to their daily tasks and lives.

The theme of Session 1 was "getting to know you." The objectives were (a) to explain the group format, including structure and weekly topics, and (b) to introduce group members to one another and allow them to share their reasons for joining and their expectations of the group. Group and center policies were included in the discussion, as well as collaboratively establishing group rules including for privacy, regular attendance, respect, issues around communication (disagreements, triggers, advice-giving), and relationships or problems that occur outside the group. During the first session, the concept of mindfulness and its benefits for emotional regulation were also highlighted, focusing on interdependence (how one affects all), compassion (for self and others), and impermanence (of emotions and experience; Hanh, 1975). The concept of *challenge by choice* (Rhonke, 2000), a fundamental principle of the group, stated that no one would be forced to share but that members would be encouraged to challenge themselves to step outside their comfort zones in order to facilitate personal growth and learning. To supplement the group experience, the facilitator recommended readings and provided information about local crisis services (Black, 1981, 1995; Gravitz & Bowden, 1985; Petit, 2010; Woititz, 1990).

The theme of Session 2 was "family roles." The objectives in this session were to (a) determine and discuss family roles, (b) learn about codependency, and (c) better understand the family system and how mental illness and/or

substance abuse can affect the family unit. The weekly activity focused on family roles and included a self-quiz from Black (2010). Codependency and transgenerational effects of being an ACOA/ACOMI also were explored.

Session 3 focused on "the mind and body relationship." The objectives were to (a) learn about the mind–body connection in relation to stress responses, focusing on the chronic stress response, and (b) learn how to become aware of stress responses and regulate them, as appropriate. The activity focused on psychoeducation regarding the autonomic nervous system and how the stress response may function differently in those individuals who experience chronic stress in childhood from those who do not (Luskin & Pelletier, 2005). Resiliency factors also were highlighted; for example, hypervigilance could be viewed as an adaptive response during childhood in a household with a parent with substance abuse/mental illness but may later cause one's body to overreact in times of stress.

"All-or-nothing thinking" was the theme of Session 4, which had the following objectives: (a) to learn about the challenges of all-or-nothing thinking, (b) to discuss and learn alternative ways of thinking, and (c) to learn how this style of thinking especially applies to the ACOA/ACOMI population. The facilitator provided group members with a worksheet on all-or-nothing thinking developed by the first author. The group then explored how these thought patterns affect perception, decisions, and relationships for ACOAs/ACOMIs. A basic cognitive-behavioral thought record was then given, focusing on restructuring these thinking patterns to "find the gray zone" and/or hold space for dichotomous thought patterns, building on themes from past sessions (e.g., how an individual can love a family member while not wanting to engage with him or her).

Session 5 focused on "the importance of self-care" with the objectives of (a) understanding the benefits of self-care and (b) helping members assess their own levels of self-care. The facilitator emphasized differences between self-care and selfishness and provided members with a self-care inventory, adapted from Saakvitne and colleagues (Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996) by the second author, to assess different areas of their lives. Members were asked to make a small commitment to improving self-care in one area of their lives during the following week.

The theme of Session 6 was "your rights," with these stated objectives: (a) empowering members regarding their rights as individuals and (b) learning how to assess whether one's rights are being respected or violated. A personal bill of rights (Johnson, 2004) was given to each member, and the group took turns reading each right aloud. As in all sessions, during the support component of the session, members were given space to respond. This activity inevitably elicited strong emotional reactions from most members as they recognized how their rights might not be respected (e.g., the right to be healthier than those around me, the right to have an emotional reaction or an opinion). The session also provided time to explore how members might communicate and assert their rights (i.e., how to create and maintain healthy boundaries), keeping multicultural considerations in mind.

Session 7 followed with the theme of "building support systems." Objectives for this session included (a) becoming aware of one's current support network and (b) identifying ways to create *families of choice* and to strengthen one's support network. Discussion took place regarding the importance of a

support network and normalizing potential lack of support from those struggling with substance abuse and/or mental illness. A families-of-choice activity (Green & Mitchell, 2008) helped members identify various individuals who may or may not provide necessary support, including financial, emotional, or physical support. Further discussion included strategies for communicating with identified families of choice to obtain ongoing support.

The eighth and final session focused on "saying goodbye," with the following objectives: (a) reviewing one's own and others' contributions to the group, (b) examining what members gained from the group and the progress they may have made, and (c) saying goodbye to the group. A majority of the time was taken up by a closure activity in which members anonymously wrote phrases of appreciation for each member. After this, each member reflected on the phrases of appreciation they received and chose one to read aloud so that other group members could witness this acknowledgment. The support component emphasized processing the closure and termination of the group. A program evaluation was provided via an online survey so group members could provide anonymous feedback to group leaders. A copy of the complete manual, including recruitment strategies and group handouts, is available from the first author upon request.

Participant Recruitment and Demographics

Given the historical difficulty of launching therapy groups at our university, we needed to market the group widely across campus and within our center for Counseling and Psychological Services (CAPS). We distributed flyers to several different departments, groups, and organizations on campus. Those providing the most referrals included the Department of Education (especially the master's programs in clinical and counseling psychology), School of Law, Residence Life, and Disabilities Resources. Information about the program was distributed through in-class announcements and in flyers that were e-mailed directly to students or shown on television via the university's electronic announcement system. In addition to this broad, university-wide recruitment effort, we recruited within CAPS and our student health clinic. This allowed for relationship building between CAPS and various campus stakeholders, provided a sense of joint ownership over the Successful Survival group's success, and likely enhanced the overall support network on campus. Moreover, after the first quarter, several members were referred via word-of-mouth from students who had previously attended the group.

During the recruitment period, interested students were asked to schedule a brief group evaluation interview with the group leaders. These evaluation interviews were 30-minute individual sessions, during which clients were assessed to see if they fit one or more of the following criteria: (a) intense suicidal or homicidal ideation and/or active intent; (b) denial of their own substance abuse and/or active substance abuse without being in current treatment; (c) strong personality characteristics that would complicate interpersonal interactions; (d) disordered eating behaviors requiring medical monitoring; (e) active psychosis; (f) history of frequent cancellations or no-shows at CAPS; or (g) a presenting problem or desired goal for treatment that did not align with the group's purpose. This interview also provided an opportunity for potential members to learn more about the group, to share their subjective

experience of being an ACOA/ACOMI, to state their expectations of the group, and to discuss any apprehensions or concerns they might have.

Group demographics indicated a fairly diverse mix of students in terms of ethnicity, level in school, whether they were a first-generation college student, and gender. For fall quarter, five group members were undergraduate and three were graduate students. One member identified as Latino, one as South Asian, and six as White. All identified as heterosexual. Five group members identified as female and three as male. One identified as a first-generation college student. For winter quarter, three members were undergraduate and four were graduate students. One member identified as Black, one as Latino, three as White, and two as multiracial. Six identified as heterosexual and one as bisexual. All identified as female. Three identified as first-generation college students. For spring quarter, four members were undergraduate and six were graduate students. One member identified as Black, one as East Asian, seven as White, and one as multiracial. All identified as heterosexual. Seven identified as female and three as male. Three identified as first-generation college students, and three were international students. Yalom and Leszcz (2005) suggested the optimal size of groups is around seven to eight members for maximal interaction, cohesion, and alliance. This was our target size for each quarter, especially because we hoped to create a sense of intimacy and trust to enhance support and reduce stigma, guilt, and shame.

Clinical Training

Because the Successful Survival group was facilitated by a supervising licensed staff psychologist and a predoctoral psychology intern, it offered several opportunities for clinical training, supervision, and skill building. Prior to group implementation, several hours were set aside for group planning, which allowed the facilitators to (a) discuss goals for the sessions; (b) plan schedules for the sessions; and (c) prepare the necessary psychoeducational materials (including information on materials, supplies needed, objective, and structure).

Weekly half-hour supervision occurred just after each group session and focused on two main components: (a) reflections on the session, including content, group member participation, themes, and challenges; and (b) reflections on the facilitators' group leadership, including facilitation style, elicitation of participation, and effective teaching of the material. One issue that arose was how to support members who felt particularly triggered by a session, such as by providing a space where those members who felt unstable or particularly distressed could meet individually with a facilitator. Other issues included how to encourage equitable group participation, make process observations, and balance the psychoeducational component with the support and discussion components. Another important topic of supervision was how to manage the dual relationships leaders had with group members who were also individual therapy clients, a situation that occurred with one or two members per quarter. This issue was explored thoroughly in consultation with other CAPS staff.

The second author was introduced to the group as a coleader and a doctoral student in her final year of training. Prior to coleading this group, she had observed other groups, gained experience as a process observer, and designed and facilitated a

nonclinical life-skills group. This was the second author's first experience providing group therapy. In the fall quarter, she played a secondary, observatory role as the staff psychologist led all sessions. In the winter quarter, she led the psychoeducational component of two sessions. In the spring quarter, she led four sessions from start to finish. Thus, much of the training occurred in a stepwise fashion during the course of the year. It incorporated a combination of hands-on, in vivo training and observation, supervision and skill building, and training through books and print materials. This developmental model allows supervisors to "meet trainees where they are" in their training and growth as independent clinicians.

Challenges and Suggestions

In our experiences running the Successful Survival group, challenges began as early as the screening process. We chose to allow students to self-identify themselves as ACOAs/ACOMIs and emphasized that no formal assessment or diagnosis of their parents was needed for group participation. Rather, appropriateness for the group was based on the student's subjective experience with the identified parent(s). Thus, it was important for the screening clinician to pay close attention to students' experience to ensure their experience and interests in the group aligned with the scope and goals of Successful Survival.

Another common challenge members presented was the "I don't belong here" mentality. It was not uncommon for members to express concerns such as, "My problems aren't as bad as others' problems" or "I don't belong here because my parents are stable and/or sober right now." This presented overtly, with clients making such statements, as well as more subtly, with clients withdrawing from group conversation or missing sessions. Clients were encouraged to present these questions to the group as a whole. In our experience, members bonded by sharing similarly held misconceptions and validating one another's struggles and experiences. Members openly expressed that they appreciated and valued the contributions that each member gave to the group. This helped to facilitate group cohesion and a sense of purpose for continuing to attend the group.

Another challenge involved the desire of some group members to share their experience with others outside of the group. For many students, this group was their first experience with any type of therapy, and some were very excited to learn about the content presented and share with partners, friends, and family. Students were encouraged to share the information they learned from the psychoeducation components, as well as new insights they learned about themselves or their family, while keeping content that others shared private. On more than one occasion, however, members requested to bring a family member, friend, or partner with them into the group space. The group explicitly prohibited this to protect the safety and privacy of members attending.

Implications and Future Recommendations

Group Evaluation and Future Groups

Given that we did not have the resources to formally evaluate Successful Survival group outcomes, future studies should examine effectiveness more

closely via quantitative and qualitative approaches. For our group, important questions would include addressing the aforementioned group goals and how well group members felt they achieved those goals. For example, questions relate to the degree to which the group helped members better understand themselves, their families, and their current relationships; learn strategies to manage stress and engage in self-care; reduce feelings of guilt, shame, and isolation; and increase ability to manage boundaries and relationships with family.

Several group members expressed interest in participating in the same group again, which was not permitted, or engaging in a different group with the same focus. Creation of a Phase 2 group may be helpful. Our recommendation is for the follow-up group to focus more on support and process as individuals attempt to implement the skills taught in Successful Survival. In this way, ACOAs/ACOMIs would be able to continue supporting one another by seeking suggestions and guidance and exploring intergroup dynamics that may elucidate patterns in other relationships.

Recruitment

Our recruitment experience suggests that a campus-wide approach is the most fruitful way to find students who are interested in participating in a group, especially those students who are not already CAPS clients. In our Successful Survival group, identifying key stakeholders around campus, including staff/administration and student groups/representatives, was a purposeful and intentional part of the recruitment process. In doing so, we created a greater sense of community within the campus. This campus involvement helps to (a) reduce stigma around mental health issues, (b) provide more clarity about specialty areas of staff and what services CAPS provides, and (c) create liaisons between various university departments and student organizations with CAPS staff. This involvement also allows for a joint sense of ownership in the group's success. Thus, we highly recommend this unified campus recruitment approach, especially in targeting the diverse populations that were underrepresented during the three quarters that our group ran (e.g., lesbian, gay, bisexual, transgender, and questioning or queer groups on campus and international student groups).

Additionally, we also recruited within our health and counseling center and found this to be a successful approach in finding appropriate group members. As with campus-wide recruitment, this process required close and frequent communication with the counseling and medical staff via e-mails, flyers, and in-person meetings and consultations. These interactions also increased center-wide sense of community and common purpose. While we have yet to assess this empirically, it is likely that recruiting existing clients allowed us to better address these students' needs, reduce burden on individual therapy appointments by teaching valuable skills and education, and further reduce clients' distress and improve their well-being.

Parcover et al. (2006) suggested process/interpersonal groups are easier to recruit and run on college campuses than structured, issue-specific groups, but we did not find this to be true. Identifying a topic for a psychoeducational support group that closely aligns with the needs and struggles of a particular counseling center's population is crucial when creating and launching an

issue-specific group. While a formal needs assessment would be ideal, a simple inventory of current and past presenting problems, as discussed during supervision, staff meetings, and case conferences, was sufficient for our purposes.

Clinical Training

Our model for group facilitation (i.e., a staff member paired with a trainee) has important implications for clinical training. We strongly suggest using this model, as the group is well-suited for building skills in psychoeducational group facilitation. Specifically, we suggest the same staff–trainee pair run the group together throughout the year. Our university's quarter system allowed three opportunities to practice and increase trainee group facilitation. Although a stepwise approach allows supervisors to work within the trainee's developmental stage, we suggest that trainees become involved from the beginning, including by leading sessions from start to finish once they become familiar with the group and their role as a leader. This direct experiential approach seems to allow for maximal increase in self-efficacy around group leadership and for better connections between the group members and both of the leaders. Similarly, if a trainee has previous experience with group facilitation, we recommend the supervisor delegate greater responsibility to the trainee at a developmentally appropriate level.

Once a group has successfully launched and run for a few quarters or semesters, we encourage group leaders to create manuals that provide (a) recruitment strategies and resources, such as contact information for campus stakeholders and sample e-mails and flyers; (b) outlines for each session; and (c) copies of all relevant handouts. Doing so allows for a more streamlined, time-effective, and consistent group preparation process and ensures that facilitators have a focused approach to each session. We encourage trainees to create these manuals to obtain a more in-depth understanding of the group, provide a deeper sense of ownership over the group, and ensure greater self-efficacy regarding group facilitation.

UCC Services

It is a well-established trend that UCCs are seeing a higher volume of students than in the past, as well as a greater severity in presenting problems (Erdur-Baker et al, 2006; Gabriel, 2010; Guess, 2008; Munsey, 2010; Smith et al., 2007). Thus, any UCCs looking to better utilize available services and reach a greater number of students should consider running these groups. Many of our group members were existing CAPS clients, and several decided to discontinue individual therapy during or after the group because they reported their needs were adequately met through the group. We also had several group members whose only contact with CAPS was participation in the group. We did not formally track this, and future studies may want to do so to determine whether participation in group therapy reduces client utilization of individual therapy.

Researchers may want to assess severity of group members' presenting concerns via common questionnaires, such as the Counseling Center Assessment of Psychological Symptoms (CCAPS; Locke et al., 2011), and establish the mean severity/distress level of group clients. In our experience, many of our clients

seemed to be experiencing marked clinical distress due to their struggles with family and other mental health issues. Thus, we were able to address the needs of several distressed students in one setting. Future research could examine CCAPS scores on relevant indices, such as the distress index, and establish a mean pre–post distress score for each group, to further highlight the distress level of this population and changes in functioning after receiving services.

The Successful Survival group also provides a valuable service to the broader university community. Group members learn evidence-based coping strategies, such as mindfulness skills, which they can then use in other areas of their lives. Furthermore, the psychoeducational support group model allows students to gain insight and learn these skills simultaneously and permits several batches of students to obtain these services over the course of one academic year. In the future, researchers might consider measuring the type of skills learned and the degree of insight learned about self, family dynamics, and coping style to understand the benefits of group membership.

Conclusion

Researchers have indicated an exponential increase in the utilization of services at UCCs over the last decade (Gabriel, 2010; Guess, 2008; Munsey, 2010). These increases have forced UCCs to become more creative in using limited resources to meet the ever-increasing demands of campus communities. Even with the strain on access to individual therapy, Parcover et al. (2006) indicated that many centers struggle to offer groups that are successful (as measured by interest, attendance, and member feedback). The purpose of this article is to provide one example of running a successful group on a college campus for an important population that often presents with risk factors and significant mental health needs. We hope this approach can serve as a model for UCCs to replicate similar issue-specific groups in their centers and best meet their students' needs.

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