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Preparing the New Client for Functional Analytic Group Therapy

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Functional analytic group therapy uses natural occurrences of clients' problems in the group to promote change. It focuses on parallels between the daily life issues for which clients seek treatment and their experience in session. When an issue shows up in the group interaction, the leader helps make it into an in vivo learning experience. The rationale is that unrehearsed experiences offer opportunities for learning that are more genuine and better tailored to the client's needs than prepared treatment activities. However, many prospective clients expect to talk about their problems instead of experiencing them and working on them in the moment as they arise. This article describes an experiential prescreening strategy that prepares for solid informed consent to a treatment that seeks therapeutic change through unplanned experiences in the group. Candidates engage in the construction of a working case conceptualization that anticipates how in-the-moment learning in the group can promote their therapeutic goals. During the interaction with the screening clinician, they learn to track target behavior and experiment with in-the-moment disclosure, acquiring experience with the tasks they will perform in the group. These elements are presented in a how-to framework, with examples based on the authors' experience.

Functional analytic group therapy (FAGT) is a behavioral treatment that capitalizes on the observation that shared openness and vulnerability in a therapy group facilitate learning experiences that can bring key changes to the client's life (Vandenberghe, 2016). Group members are encouraged to engage mindfully in interactions, explore challenging situations as they occur, and support each other's efforts to deal with difficulties. What makes FAGT different from many behavioral group treatments

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is that healing is sought not through didactic training but rather in turning the person's experience in the group, with the help of other participants, into an *in vivo* learning opportunity. This view draws on the tenets of a model for individual treatment settings called functional analytic psychotherapy (FAP) (Holman, Kanter, Tsai, & Kohlenberg, 2017; Tsai, Kohlenberg, Kanter, Holman, & Loudon, 2012). To understand this point, let us first turn to these authors' work.

The basic assumption adopted from FAP is that the interpersonal experiences in clients' lives shape their presenting problems. Within this framework, what is emphasized is the way people respond to the behavior of others. These interactions are mostly adaptive. They shape the repertoires by which we deal with daily life. But important others may react poorly to "adequate behavior," thereby weakening it, and they may respond to "problem behavior" in ways that reinforce it. Curative interactions should do the opposite. Like individual FAP therapists, functional analytic group therapists start out by identifying the client behavior that contributes to the presenting problems. They believe the remedy for many of the client's complaints will come from the client behaving differently in crucial situations. Clinical progress may then come from new behavior that enhances genuine interpersonal connection and improved navigation of daily life challenges.

According to the FAP model, clients in psychotherapy improve when the relationship with the therapist creates a space in which clients' problems can occur, allowing the client to deal with them during session, with the therapist responding contingently to the client's efforts in a manner that reinforces enhanced client behavior. Thus, clinical progress is seen as resulting from what happens in the client's relationship with the therapist. FAP therapists watch for a client's clinically relevant behavior (CRB) in session. In the case of an unassertive person, that behavior may be avoiding intense contact with the therapist. When clients do not demonstrate the problem behavior for which they are seeking treatment, the therapist will try to evoke it through an intervention that brings the clients' problems into the room and makes it relevant to the relationship with the therapist, thereby creating learning opportunities.

When the client exhibits the behavior that in daily life contributes to their problems (hereinafter referred to as CRB1), FAP therapists respond in ways that weaken that behavior. On the other hand, they respond to behavior that will help improve the client's problems (called CRB2) in ways that will strengthen it. To be certain that they are effectively supporting improved target behavior, FAP therapists track the effects they have on the client's behavior from session to session. When progress is noted, they discuss parallels between what happens in session and in the client's daily life and help generalize improvements obtained in session to other relationships.

THE GROUP AS A SPACE FOR
TRANSFORMING RELATIONSHIPS

When the FAP model is translated to group therapy, interaction with the group's other members—not just with the therapist—brings clients' problematic behaviors into the room and provides the sought-for curative learning experiences. Participants' treatment goals are broken down into specific difficulties and target behaviors for which *in vivo* learning opportunities must be found. This is possible when, experiencing the same difficulties that underlie their daily life problems, clients display either behavior they typically use to deal with those problems or new ways of responding. The case formulation must determine whether the behavior is CRB1 or CRB2. For instance, speaking up or holding one's tongue may be an improvement for one client or a problem behavior for another.

What does a functional analytic therapy group look like? It is a space for personal encounter and interaction primed to evoke clients' issues and allow experiential learning. Sessions must be long enough to allow helpful learning experiences. That may be between one and a half and two hours for the typical five- to ten-member group. In our experience, up to 10 sessions can be enough to allow reliable improvement in how many people deal with their problems. But in the absence of hard data, no standard number of sessions is set forth, and the therapist must make that determination based on the group members' needs and the overall therapeutic context.

In most groups, CRB1 readily shows up (e.g., when a participant with trust problems rejects support from other members or a client with assertiveness problems struggles to make a simple request). In the first case, CRB2 that can be developed in the group may consist of conceding that others may have good intentions and giving them a chance to help. The help obtained may then strengthen that new behavior, meaning that the person may become more likely to allow people to support him or her in the future. In the second case, possible CRB2 may consist of taking a risk by requesting something of the group. The group may grant what the person asks for or otherwise honor the request in a way that provides natural reinforcement for the behavior.

As the group's spontaneous responses to the members' CRB are harnessed, the arbitrary nature of educational interventions is avoided. The therapist does not teach interaction skills. Instead, participants share the impact other participants have on them. In doing so, the person whose CRB caused the impact can experience the effects it has on other people, including effects that in daily life interactions might remain hidden or difficult to decipher. The treatment is experiential in the sense that people change during, and because of, genuine experiences in the group and not through didactic training.

Group leaders—typically two clinicians in the second author's practice, whereas the first author leads her groups alone—are most active during early sessions. Orienting, explaining, and promoting inclusion help set the stage for a cohesive group.

They focus on helping each member engage fully in the group and on shaping exchanges that have a high likelihood of evoking and reinforce members' CRB2. With clients' case formulations close at hand, they encourage the kinds of interaction in which the clients' problems become relevant and support trying out new behavior directed at their target outcomes.

Over time, the group will come to shoulder the tasks that in individual FAP are allotted to the therapist (see table 1). But when a group avoids relevant issues, misses improved target behavior that should be reinforced, or reinforces a member's problem behavior, the leader must continue to coach it toward openness and connection. In any case, group leaders help trace changes from session to session, and when someone makes significant progress, they invite the entire group to help devise homework activities that can help that participant transfer the improved target behavior to daily life. During later sessions, all members engage in follow-up discussions about how what they learned in the group works for them outside the group.

FUNCTIONAL ANALYTIC GROUP THERAPY: AN OVERVIEW

Hoekstra (2008) and Hoekstra and Tsai (2010) described hypothetical group interactions illustrating how interpersonal process groups can be structured according to FAP principles, with the therapist identifying or evoking CRB for which the group provides opportunities and with the therapist fostering a relationship with the group member and the group that can reinforce CRB2. They argue the case for therapists attending to their private responses to a group member's behavior as a means of tracing CRB and to potentially reinforcing effects of their responses to client CRB. The group leader's task involves constructing functional interpretations about the client's behavior in the group and sharing them, blocking CRB1 and engaging members in providing functional statements about each other's behavior.

Vandenberghe (2009) reviewed earlier functional analytic groups with the focus on their proposed active ingredients. Client behavior that sabotages interpersonal interactions in daily life often turns up in the groups as a CRB1 that hurts other group members, and a CRB2 that helps connect to people in the group may also improve the client's regular relationships. Therefore, the group's open display of its genuine reactions to both types of CRB will serve as experiential feedback. The group is helpful when group members' natural responses weaken CRB1 and evoke and reinforce CRB2.

A rationale for such groups' therapeutic action has been detailed in the form of a framework that distinguishes between two types of group patterns, called G1 and G2 (Vandenberghe, 2016). An *in vivo* learning opportunity for a client typically starts when the interaction with other members poses difficulties to which the client responds with his or her usual problem behavior or with improved target behavior, to which the group then spontaneously responds. The term "G2" is applied to exchanges in the group that weaken the problem behavior and reinforce

TABLE 1. The group as a therapist: The group takes over the tasks of the therapist

FAP individual therapist	FAGT group leader	FAGT group members
Create an intense and curative relationship	Shape therapeutically helpful group interaction patterns	Engage with an open and mindful attitude
Watch for and evoke client CRB	Watch for and evoke client CRB and relevant group interactioan patterns	Track own CRB, what evokes it, and what it evokes in other group members
Respond contingently to CRB	Promote group's contingent responding to CRB	Respond contingently to others' CRB
Track effects of therapist on client behavior and vice versa	Track client changes as a function of therapist or group responses	Track effects of own behavior on others' behavior and vice versa
Promote generalization of improvement to daily life environments	Discuss generalization strategies for improvement	Help plan generalization of own and others' improvement

Source: Summarized from Vandenberghe (2015).

target behavior. When the group reinforces problem behavior or weakens target behavior, we refer to it as "G1."

A productive group provides the support needed for participants to examine their behavior as it happens, label the costs of the ways in which they deal with their issues, and move toward change. This may demand some careful prompting and coaching from the group leaders, who will often act as stewards, supporting healing exchanges (G2) and blocking unhelpful interaction patterns (G1). Group leaders therefore must not only help track individual participants' CRB but also continually assess the group's response patterns and, when needed, influence them (Vandenberghe, 2015).

There are no studies that allow us to identify which clinical issues respond best to this type of group therapy. The first author uses FAGT primarily for women who struggle with affect regulation and emotional reactivity, with no data published at present. Vandenberghe (2009) reported the use of FAGT for groups for individuals with chronic pain and depression. And although no specific factors have been identified to determine why individual therapists refer patients to a FAGT group, one possible hypothesis is that the therapist views interpersonal difficulties as prevalent in the candidate's presenting problems for FAGT to be a favored as a treatment.

Although Vandenberghe (2009, 2016) analyzed vignettes exemplifying curative exchanges and reported on individual clients' clinical progress, controlled outcome studies are still lacking. A feasibility study (Vandenberghe & Leite, 2018) involving three groups in a free community clinic found improvement in 12 out of 20 treatment completers to be both reliable and clinically significant. During prescreening,

clients easily accepted the rationale for treatment. Attrition was low and attendance high, considering the time commitment required (16 weekly two-hour sessions), suggesting the approach made sense to participants. Therapists who had learned the treatment at the site while applying it under standard supervision conditions implemented it effectively, which makes it a feasible option for the typical community mental health care setting.

FAGT PREPARATION

To profit from FAGT, clients must have some insight into their problems and be open to learning from what happens when their problematic responses are evoked in the group. This need can be addressed with good conceptual working agreement that identifies target behavior and on how it might show up in the group.

First, the need to track CRB in the group may puzzle people who expect to discuss their daily life problems in a distanced fashion and learn about them from a "there-and-then" perspective as opposed to experiencing them here and now. Also, when they seek help, clients often are not quite aware of the role of their behavior in their presenting concerns. Discovering how one's behavior operates on an interpersonal level may be painful. Finally, practices such as directly addressing CRB1 in the moment or questioning the function of ongoing behavior can leave an unprepared client baffled.

These are some reasons why informed consent must be carefully obtained. If the clinician does not know the client (e.g., from previous individual sessions), this may take up two or three sessions. Two examples of treatment failures can illustrate the need for a prescreening routine.

Consider a client whose condescending comments hindered her finding genuine connection with others in her life. She came across as argumentative and invalidating both in daily life and in the group. Tracking how her behavior affected other group members might have allowed for valuable *in vivo* learning opportunities. However, after having been confronted by other participants about belittling one member's courageous disclosure, she did not recognize this as clinically relevant and left the group.

Another client's presentation of herself as very committed was recognized as part of the apparent competence she developed to keep her functioning in her daily life, paralleling the dedication she showed at her job even as her life was falling apart in multiple ways. Later in the group, she was extremely focused and effective in responding to others' issues, but she did not acknowledge the avoidant function of this behavior, nor did she take the opportunity to learn to accept and deal with uncontrollable events in the group. She then left abruptly, claiming the group did not have enough structure.

The remainder of this article presents a how-to model that was written to share the authors' experience with clinicians in the field to help prepare clients for this

type of group and to enable research on whether and how such prescreening influences the process and outcome.

ASSEMBLING A GROUP

Clinicians look at how candidates may benefit from a group, how they will function in it, and whether they have the commitment and skills needed (American Group Psychotherapy Association, 2007). A Group Selection Questionnaire, measuring expected benefit, interpersonal skill, and hindering demeanor (e.g., inapt disclosure or arguing) predicted both process (e.g., cohesion) and outcome (Burlingame, Cox, Davis, Layne, & Gleave, 2011). A revision, called the Group Readiness Questionnaire, had good convergent validity (Baker, Burlingame, Cox, Beecher, & Gleave, 2013) but needs further research as to predicting outcome.

Traditional CBT group screening starts by providing information on the treatment and asking candidates to help produce a list of personal goals. Clinical judgment and informed client opinion redirect people who will not benefit from the group or who will detract from the therapeutic process because of comorbidities or lack of skills (Free, 2000; Sank & Shaffer, 1984). Sank and Shaffer described how informed consent is then facilitated by providing illustrations of group activities tailored to the candidate's needs.

This method also works in screening for FAGT. After explaining the notion of *in vivo* learning and the treatment tasks (third column in table 1), clinicians encourage candidates to specify their goals and how they expect engaging in this type of group might be helpful. Importantly, candidates need to be ready to do work in the here and now, on unplanned incidents in the group (as opposed to structured activities or learning modules in many CBT groups), during which their personal concerns and goals become the stuff of group discussion.

THE GOODNESS-OF-FIT CONUNDRUM

In the group, one person's prosocial behavior may encourage another's openness and courage. Someone's problem behavior may also evoke others' issues and offer *in vivo* learning opportunities for them. Disruption of group communication because of one participant's inapt behavior can mobilize group members and put them in a situation from which they can learn. Thus, what seems counterproductive, such as inadequate disclosure or talking over others, may be clinically relevant and can be targeted for change in the group. It can also introduce challenges that offer learning opportunities for others.

Clinicians try to imagine how each candidate will cope with each of the others' expected CRB and how it will evoke other candidates' CRB. A detailed working case conceptualization for each candidate is recommended in order to accomplish this. The agenda is to prepare for work on behavior that is expected to challenge the

group experience and not to keep it out of the group. Even so, people who cannot identify their problem behavior, are not responsive to feedback, or are unwilling or unable to work toward specific goals may not benefit from this type of treatment.

The first author's clients tend to be educated women with mood regulation difficulties. Most of them have had experience with individual therapy, are referred by individual therapists, or are self-referred through the first author's website. The second author's first FAGT clients were referred by a pain clinic (Vandenberghe, Ferro, & Cruz, 2003). Later groups most often served women with depression at a free community clinic. Most of the women previously had some individual therapy and were referred by their psychiatrists. FAGT typically serves people who see their problems as interpersonally based, which presupposes self-observation skills and tends to exclude certain individuals with a psychotic disorder or severe character pathology.

PREPARING FOR INFORMED CONSENT TO *IN VIVO* WORK

Does it make sense to candidates that the issues considered during screening are expected to show up in session? Do they see how they may learn from that? Three objectives must be met before someone can consent to the *in vivo* learning procedure. First, candidates and therapists need to discern the behavior that will be targeted in therapy. Second, the candidate's attention must be oriented to the *in vivo* process to prepare him or her to track the behavior during group interactions. Third, candidates are invited to have had the opportunity to experience the tasks involved in the *in vivo* work to which they are consenting.

When starting a new group, the group leaders will be at an advantage if they have each participant's most obvious CRB well in mind in order to understand quickly enough what goes on for that person at a given moment in session. This may also involve identifying with the client what an improved response might look and feel like. The screening activities that follow should create a foundation for a shared understanding between candidate and clinician about what behavior should be targeted in the group to provide the help the client needs.

Define Target Behavior

Finding out what client behavior to consider in the case conceptualization can be difficult when clients describe their problems in a fuzzy or abstract way or when they see only how other people contribute to their problems. Screening clinicians can try to identify relevant behavior by asking questions about how candidates respond to situations or challenges that seem to cue the candidate's problem behaviors. They can explore daily life events for concrete information and propose self-observation assignments to obtain added data.

Identify Customary Client Responses

Defining target behavior may require dedicating time to how candidates most often tend to respond when their issues are triggered. The clinician might ask questions such as, "If you feel rejected, would someone who saw you notice you doing something different?" followed by, "Can you give me one or two examples of when you responded in such a way?" From these interactions, a form can be prepared with blanks to be filled out, based on available intake information about the candidate's presenting problems: "When I feel excluded, I tend to _____," or "I _____ when I feel unprotected." The answers can then be discussed with the intention of identifying responses to key situations that feature in the client's complaints and to daily life challenges the clinician hypothesizes to be relevant for the problems based on the complaints.

Asking questions about the candidate's experience of the interviewer and the screening situation can both produce additional detail and offer opportunities to exercise the client's self-observation: "Did anything like what you just described come up for you during the interview?" "Did you have a feeling of being unprotected anytime during this interview?" "Did anything happen in our session that is similar to what happens in the kind of encounters you just described?" Also, complete-the-sentence cues about the screening context are included in the form: "When I get anxious during these interviews, I might _____."

To decide whether the responses qualify as relevant problem behavior, the clinician needs to put them in context. Do they obstruct the development of valued interpersonal connections with other people? Do they hinder problem solving? This opens the discussion about how the same responses might present in the group and how the client imagines they will affect other participants. Answering such queries at once prepares candidates for tracking their responses later, in the group.

Examine Daily Life Interactions

Because clients often seek treatment when issues affect them more than usual, the weeks preceding the interview generally offer enough material to allow a functional understanding of the problem that will later inform what happens when the same issues show up in the group.

People seeking help for escalating arguments will probably be able to describe typical sequences of behavior that occur in the run-up to a fight, but some may need extra questions to discern how their behavior contributed to the escalation. Someone with a long-standing silent depression might have difficulty bringing up anything concrete, and the clinician must help them identify relevant incidents. Such candidates may be encouraged to tell the clinician about the parts of their life, such as family, profession, or friendships, where their distress shows up and how they address it in those areas.

These queries aim at identifying what situations or encounters typically precede the distress, what feelings or intentions accompany it, how the person's reactions influence the situation, and what results they bring about. The intention is to get a picture of the interpersonal patterns that thwart building truly nurturing connections with others or interfere with solving the problems that encumber the candidate's life.

At the same time, the discussions offer a picture of the candidates' understanding of interpersonal interactions. A deficit in this ability may be part of the client's daily life problems and may become a target for development in the group. The screening situation may be an opportunity to start working on it. This is possible when the clinician can harness a relevant occurrence for this purpose, for example, by asking the client to analyze it: "I just noticed you stopped looking at me and you haven't really answered my last two or three questions. Can you tell me what was going on for you? How might this influence an interviewer like me?"

Propose Self-Observation Assignments

This can take the form of journal writing or voice recording at the end of the day. Prepared forms with column headings such as "What happened first, what I did, what happened next, etc." may unearth information that is hard to access through interviews. For example, a client's bulimic behavior may help her avoid looming arguments with her mother or function as a way to communicate about an ineffective interaction.

Even when an interview has been productive, an assignment can provide additional detail and nuance. It can bring context into the picture and assist in formulating improved queries about precipitants, vulnerability factors, and situational demands. A written contingency analysis, as used in dialectical behavior therapy (Carmel, Comtois, Harned, Holler, & McFarr, 2016), may help clients get a new view on their problems and increase their interest in the treatment. The assignments can also provide paradigmatic situations that can later be revisited when the same issue comes up in the group.

After the clinician reviews the report, the conversation with the candidate might go something like this: "It seems as if in the examples you reported, this feeling of being excluded shows up in a sequence of events in which expressing yourself effectively comes on the radar. If the group was able to give you feedback on ways you could express yourself more effectively, would you be willing to hear them out?" The clinician may ask, "Would you tell us whenever you feel cut off or unable to express yourself in the group?" or "Can we ask the group to keep an eye on times where they can help you express yourself in a way that works for you?"

The assignment cues enhanced attention and can be an opportunity to develop tracking skills. Additionally, when a client has difficulties completing the assignment or sharing it with the therapist, delving into those difficulties may help the

therapist learn more about the client's issues. These same self-observation skills will be needed in the group, and the quality of the observations the client comes up with allows the clinician to gauge which skills need improvement. Is it difficult for them to identify their needs and goals in a situation? Do they see how they contributed to the situation, or did they notice only what the others did? Again, the clinician may harness real situations as opportunities for training these skills during the interview: "I guess my last comment was somewhat invasive. Did you notice how you reacted?" or "What do you think that was like for me?"

Use the Clinician–Client Relationship

Candidates may evade eye contact, speak softly or loudly, downplay emotional pain, provide excessive detail, or become tangential during the interview. They may be insensitive to the clinician's needs or make the interview unproductive through long silences, acting confrontational, or distracting by amusing performance. Observing this behavior can add information to the content of the client's talk. Once it is detected, the clinician verifies whether it is relevant to the client's problems. If this is the case, it may be expected to show up in the group, where the person will be seen remaining silent, telling stories that do not relate to group focus, becoming sarcastic toward other members, or avoiding difficult issues by entertaining the group.

It is useful to set the stage for such observations at the first screening session, saying, "As we do this interview, I'm already interested in things that might happen here between the two of us that are related to the reason you came for therapy and that might also show up in the group." Throughout the screening sessions, the clinician labels potential CRB, saying "I notice you (describe the behavior)," and then checks its relevance directly with the client: "I'm noticing that as you are talking about this problem, you joke around. I want to pause you a minute to see whether you noticed this as well. In what kind of situation, outside of here, do you tend to do this, and what kind of impact does this have on the situation?"

When the clinician has enough information, she can offer a hypothesis: "Does that help you minimize the pain?" or "I'm concerned about what you might be avoiding by doing this and whether it makes it hard for people to really understand what you feel. Can this make you miss out on enriching connections?" As another example, the clinician may say, "I'm noticing that you talk over me a lot, and you tend to 'overexplain.' [Shares an observation about client behavior.] At times I'm struggling to stay on task. [Shares the client' effect on the clinician.] I'm wondering whether this behavior shows up when you worry about being heard or about the other person 'getting' you. And it may hinder that person getting involved. [Suggests a hypothesis based on the effect the client has on the therapist.]"

Client behavior that facilitates the interview may be helpful in daily life. Clinicians bear in mind that when someone's issues are related to their inability to open

up to other people about their problems and needs, any useful disclosure during the interview may already be a CRB2 that should be pursued by the group. But the opposite may also be true: Giving very detailed descriptions and rigidly following assignment instructions may be helpful for the clinician but may encumber the client's interpersonal relations in daily life.

Orient Toward the *In Vivo* Process

Explore the Concrete Experience of Daily Life Problems

Identifying the experiential qualities of a client's issues will help the clinician detect them later, when they will show up in the group ("What made you notice you were overwhelmed by this incident?" "What kept you from asking for what you needed?" "What did you feel like doing?"). The client gets a better sense of the issues and will be better prepared for recognizing them in the group, when here-and-now questions will be asked about the same experiences ("Is there anything the group could do that would make this experience less overwhelming?" "Is there something you might need and feel you can't ask for?").

Answering such questions during prescreening helps orient the candidate's curiosity to the *in vivo* process. It heightens the awareness of the problem behavior's function and of the possibility of choosing alternative responses. The question-and-answer activity also allows the clinician to assess how well prepared and willing clients will be to track their behavior in the group.

Build Willingness to Work on Problems in the Moment

Asking candidates to discuss their behavior and its impact on others in daily life helps them get a feel of the work to which they are asked to consent. This makes it easier for the client to understand the rationale for working on the pattern they explore, when that same pattern will show up during treatment: "If you find yourself doing this in the group, would you agree to stop in your tracks right there and see if together we can just be curious about it? Like, what were you needing or feeling as you did that? [Checks commitment to *in vivo* work.]"

Preparing the client for *in vivo* work need not wait for a discrete part of the interview. A screening clinician who has arrived at a workable definition of a target behavior and has gotten an affirmative response to a question such as "If this comes up in the group, where there is a difficult topic on the table, and you start doing something like this, would you be willing to monitor this? [Orients client curiosity to group experience.]" The therapist may then proceed directly, asking, "And would you allow us to help you notice when this happens? [Checks willingness to engage in *in vivo* work.]"

Use the Clinician–Client Relationship

Prescreening should give clients a chance to practice tracking. The clinician can say, "You've talked about this sense of being insecure, which can lead up to drinking or picking fights, and that it can show up in more subtle ways and long before you drink or get into a fight. If you notice any sense of insecurity here, would you be open to exploring that with the group?"

When the clinician uses the relationship to direct the client's curiosity to in-the-moment experience, clients will enter the group better prepared to address their behavior as it happens. It may be hard to commit to speaking up about difficulties as they are happening in the group when one has not had the opportunity to try this out in a more secure relationship such as the one with the clinician.

Offer Hands-On Experience With *In Vivo* Work

Making sure the candidate has had actual experience with *in vivo* work is a great help when it comes to obtaining informed consent to this type of work in the group. The clinician–candidate relationship during screening is the ideal place to provide this experience. Using the provisional case conceptualization, the clinician can invite the candidate to experiment with a plausible CRB. For example, the invitation to share feelings of insecurity when they show up during the interview tends to create opportunities for teaching and practicing in-the-moment disclosure and *in vivo* work. When client and clinician set to work clarifying what is happening in the moment, this may produce CRB2, such as assertively stating one's needs or identifying how the clinician evoked a sense of insecurity.

Offering such hands-on experience also helps develop the skills the client will use to benefit from in the group process. One client sat back and stared at the ceiling, becoming unresponsive when the clinician tried to identify customary problem behavior. The clinician asked her to note what was happening and asked her to wonder about how this staring at the ceiling made the clinician feel and how it influenced the efficacy of the interview. This request from the clinician created the opportunity for the client to learn to label what happens when she is confronted (she went blank, fled from contact) and to imagine how her behavior in those moments might affect other people (they feel at a loss). This *in vivo* learning experience also helped her understand that the group might confuse her behavior with indifference and that she needed to report her inner experience in order to allow the group to help.

Thus, when the clinician notes a potential CRB1, he or she helps the client become aware of it and explore how it causes problems in the clinician–candidate relationship. During this discussion, opportunities for *in vivo* learning appear spontaneously and can be worked on the same way as when they will happen in the group. It must

be stressed that these interventions target preparing the person for active participation in the group and are not expected to change the deeply ingrained patterns of interacting and feeling, which will be addressed in the actual group.

CONCLUSION

Notions such as tracking, evoking, and reinforcing target behavior may seem so simple and straightforward that clinicians may underestimate the client skills and commitment needed to make it work. This is why an explicit framework for preparing the client is needed. In this how-to model, well-known interview strategies and self-observation assignments are harnessed to help obtain an accurate agreement on target behavior the client is prepared to work on during his or her interaction with other group members.

The prescreening routine was developed to help clients decide whether FAGT is a valid choice for their problems, increase the likelihood that they are willing to actively engage in the group, and prepare them for the tasks that await them once treatment starts. It directs candidates' curiosity to the interpersonal dimension of their presenting problems and establishes their willingness to work on the problems *in vivo*. Although this routine evolved during prescreening for one specific approach, the same strategies may well be found useful in screening for other experiential group formats.

Future research can assess whether and to what extent two to three screening sessions conducted according to the ideas outlined in this article optimize group processes and outcomes. Suggested hypotheses are that, compared with prescreening as usual, this routine will improve measurable variables such as cohesion, time spent productively on treatment targets, attrition, and treatment outcome.

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