

## Group Psychotherapy Progress Note

The Group Psychotherapy Progress Note is used for billable outpatient psychotherapy groups. Use the Intensive Services Progress Note form to document other groups offered as part of programs such as Partial Hospitalization (PHP), Community Based Adolescent Treatment (CBAT) and Transitional Support Services (TSS).

Data Field	Identifying Information Instructions
<b>Person's Name</b>	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
<b>Record Number</b>	Record your agency's established identification number for the person.
<b>Person's DOB</b>	Record the person's date of birth to serve as another identifier.
<b>Organization Name:</b>	Record the organization for whom you are delivering the service.
<b>Group Name</b>	Give the name of the specific group. Example: Anger Management.
<b>Number of Attendees</b>	Enter the number of persons attending the group on this date.
<b>Person Served Did Not Attend</b>	Indicate the reason the person served did not attend the group session.
Data Field	Documentation of Person's Served Participation and Response to Group Treatment
<b>Behavior in Group</b>	Check box(es) to document the person's observed behavior during the group session.
<b>Person's Served Mood</b>	Check box(es) to document the person's observed or reported mood during the group session.
<b>Stressors/Extraordinary Events/New Issues Presented Today</b>	<p>There are four options available for staff using this section of the progress note:</p> <ol style="list-style-type: none"> <li>1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals.</li> <li>2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions section and indicate the resolution in the Response section of the progress note. If services are provided during the session that have not been previously ordered in the Individualized Action plan, then an explanation of the rationale for those services should be provided.</li> <li>3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved.</li> <li>4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form.</li> </ol> <p><b>Example:</b> Person became uncharacteristically angry with another group member during the group session and the two began arguing loudly. Group therapist intervened and assisted person with identifying what had triggered excessive anger today. Person was able to recognize that the other group member reminded her of her abusive uncle and apologized to the other member.</p> <p><b>Example of New Issue needing CA Update:</b> The person reported new symptoms of nightmares, intrusive memories, and</p>

# Documentation For Group Therapy Examples

**KJ Lindholm-Leary**



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## **Table of Contents Documentation For Group Therapy Examples**

1. Understanding the eBook Documentation For Group Therapy Examples
  - The Rise of Digital Reading Documentation For Group Therapy Examples
  - Advantages of eBooks Over Traditional Books
2. Identifying Documentation For Group Therapy Examples
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Documentation For Group Therapy Examples
  - User-Friendly Interface
4. Exploring eBook Recommendations from Documentation For Group Therapy Examples
  - Personalized Recommendations
  - Documentation For Group Therapy Examples User Reviews and Ratings
  - Documentation For Group Therapy Examples and Bestseller Lists
5. Accessing Documentation For Group Therapy Examples Free and Paid eBooks

- Documentation For Group Therapy Examples Public Domain eBooks
  - Documentation For Group Therapy Examples eBook Subscription Services
  - Documentation For Group Therapy Examples Budget-Friendly Options
6. Navigating Documentation For Group Therapy Examples eBook Formats
    - ePub, PDF, MOBI, and More
    - Documentation For Group Therapy Examples Compatibility with Devices
    - Documentation For Group Therapy Examples Enhanced eBook Features
  7. Enhancing Your Reading Experience
    - Adjustable Fonts and Text Sizes of Documentation For Group Therapy Examples
    - Highlighting and Note-Taking Documentation For Group Therapy Examples
    - Interactive Elements Documentation For Group Therapy Examples
  8. Staying Engaged with Documentation For Group Therapy Examples
    - Joining Online Reading Communities
    - Participating in Virtual Book Clubs
    - Following Authors and Publishers Documentation For Group Therapy Examples
  9. Balancing eBooks and Physical Books Documentation For Group Therapy Examples
    - Benefits of a Digital Library
    - Creating a Diverse Reading Collection Documentation For Group Therapy Examples
  10. Overcoming Reading Challenges
    - Dealing with Digital Eye Strain
    - Minimizing Distractions
    - Managing Screen Time
  11. Cultivating a Reading Routine Documentation For Group Therapy Examples
    - Setting Reading Goals Documentation For Group Therapy Examples
    - Carving Out Dedicated Reading Time
  12. Sourcing Reliable Information of Documentation For Group Therapy Examples
    - Fact-Checking eBook Content of Documentation For Group Therapy Examples
    - Distinguishing Credible Sources
  13. Promoting Lifelong Learning
    - Utilizing eBooks for Skill Development

- Exploring Educational eBooks
14. Embracing eBook Trends
- Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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