Course-EC-2 Paper 2 (Psychotherapy) Unit 1; Sem IV
By
Prof. (Dr.) Md. Iftekhar Hossain,
Head of Department, P.G Department of Psychology
Patna University
Contact No-993408701, E-mail-iftekharpupatna786@gmail.com

GROUP THERAPY

Group psychotherapy or group therapy is a form of psychotherapy in which one or more therapists treat a small group of clients together as a group. The term can legitimately refer to any form of psychotherapy when delivered in a group format, including Art therapy, cognitive behavioural therapy or interpersonal therapy, but it is usually applied to psychodynamic group therapy where the group context and group process is explicitly utilised as a mechanism of change by developing, exploring and examining interpersonal relationships within the group.

Group therapy may be utilized
(1) Independently, during which both intrapsychic and interpersonal operations are considered;

(2) In combination with individual therapy conducted by the same therapist ("combined therapy")—individual sessions deal with the patient's resistances, transferential responses to the therapist, and primary separation anxiety, while group sessions focus chiefly on interpersonal phenomena;

(3) In conjunction with individual therapy conducted by another therapist ("conjoint therapy");

(4) As leaderless groups particularly after formal group therapy has ended.

Meetings in independent, combined, conjoint therapy may take place one or two times weekly and, in institutional settings, even daily. They may be supplemented with regularly scheduled meetings that are not attended by the therapist ("coordinated meetings")—the members may congregate before a regular session ("pre-meetings"), after a regular session ("post-meetings"), or at other times at specially designated places ("alternate meetings"). Coordinated meetings enable patients to discuss their feelings about the therapist more freely. They are generally less formal and more spontaneous than regular meetings. Acting-out is more than a casual possibility here, which may or may not prove to be beneficial to the patient. ("Closed groups" maintain a constant membership although new members may be added for special reasons. "Open groups" operate continuously with new members being added as regular member's complete therapy and leave the group.)

Treatment in group therapy may be "therapist-cantered," in which therapists take a directive and more authoritarian role, moderating member-to-member communication, presenting interpretations, and limiting the patients' intragroup and extra group activities ("triangular communication"). It may be "group-cantered," in which the group operates as the primary authority, therapists functioning in a kind of consultative role.

How a therapist conducts a group is determined
1. By the goals that the therapist sets—supportive, reductive, or reconstructive.

2. By the constituent members—alcoholics, drug addicts, psychotics, stutterers, delinquents, Psycho neurotics, character disorders, patients with heterogeneous problems.

3. By the therapist's training—group dynamics, rehabilitation, behaviour therapy, cognitive therapy, existential therapy, psychodrama, psychoanalytically oriented psychotherapy, psychoanalysis.

4. By the therapist's personal ambitions and needs—characterologic and counter transferential.

ORGANIZING A GROUP

In organizing a group the therapist will be limited by the patients available. Nevertheless, one should choose patients who are sufficiently advanced in their understanding of themselves to be able to perceive their patterns as they will appear in the group setting. While the clinical diagnosis is not too important, experience shows that the following conditions and patients do poorly in a group; except perhaps when implemented by an experienced group therapist in a homogeneous group within an inpatient setup through supportive or re educative group methods.
1. Psychopathic personalities and those with poor impulse control
2. Acute depressions and suicidal risks
3. Stutterers
4. True alcoholics
5. Hallucinating patients and those out of contact with reality
6. Patients with marked paranoidal tendencies
7. Hypomanics
8. Patients with a low intelligence

The age difference should preferably not exceed 20 years. Homogeneity in educational background and intelligence is desirable but not imperative. A well-balanced group often contains an "oral-dependent," a "schizoid-withdrawn," a "rigid-compulsive," and perhaps a "provocative" patient, such as one who is in a chronic anxiety state. This variety permits the members to observe a wide assortment of defense mechanisms and to experience tensions they might otherwise evade. The number of group members may range optimally from 6 to 10. If a therapist feels uncomfortable with a large group, then the size of the group should be reduced. Marital status is relatively unimportant. A balance of males and females in the group allows for an opportunity to project and to experience feelings in relation to both sexes, although acting-out is more likely in a mixed group. A heterogeneous group in terms of age, sex, and syndrome is most effective for reconstructive goals. A homogeneous group, composed of patients with the same problem, is best for alcoholism, substance abuse, obesity, smoking, sexual problems,

insomnia, phobias, depression, delinquency, stuttering, criminality, marital problems, divorce, and geriatric problems, although an occasional person with such problems may do well with and stimulate activity in a heterogeneous group

THE OPENING SESSIONS

At the first session the members are introduced by their first names, and the purpose of group discussions are clarified. This will vary with different therapists and different groups. Newer patients may need more explanations in the group setting. The more passive-dependent the patient, the more leadership will be demanded of the therapist. The technique employed during the opening session will be determined by the therapist's orientation and level of anxiety. Some therapists begin by simply stating that the group offers members an opportunity to talk about their feelings and eventually to understand their individual patterns. It is not necessary for the members to feel compelled to reveal something that they want to keep to themselves. However, communicating freely will help them to get a better grip on their problems. For instance, each member must have had certain definite feelings about entering the group; he or she may have been embarrassed, upset, or fearful. The therapist may then attempt to elicit these emotions, and, as one member expresses freely, others will join in, leading to a general airing of difficulties shared by all. Before the close of the first session, some therapists find it advisable to stress the confidential nature of the meetings and to caution that each member is expected not to reveal to others the identity of the members and the subject matter discussed in the group. While no member will have to divulge secrets before he or she is ready, each will be encouraged to relate any incidents involving accidental or planned contacts with other members of the group outside of the sessions.

LATER SESSIONS

As the group becomes integrated and develops an "ego" of its own, members feel free to air intimate vexations. The patient gains more insight into personal difficulties recognizing that many troubles previously believed unique have a common base. The therapist should, therefore, direct energies toward stimulating thinking around universally shared problems, getting responses from other group members even though the subject under consideration is out of the ordinary. The patients may be asked to talk about personal impressions of the role the therapist is playing in the group. Thereafter the group is asked to discuss the verity of each patient's assumptions.

TECHNICAL OPERATIONS OF THE GROUP THERAPIST

The role of the group leader is to catalyse participation of the various members, to maintain an adequate level of tension, to promote decision making and problem solving, to encourage identifications, to foster an interest in the goals to be achieved, and to resolve competitiveness, resentments, and other defenses that block activity. Groups have a tendency to develop many resistances; for instance, the members form cliques, they come late, they socialize too much, they get frozen into interlocking roles.

The therapist has a responsibility to deal with these overt obstructions, as well as with those that are more concealed and come through in acts like passivity, detachment, and ingratiation. The group interactions will permit the therapist to witness how individuals function with others, their enmities, and their alliances.

Other therapist activities include
1. Focusing the conversational theme around pertinent subjects when topics become irrelevant.
2. Creating tension by asking questions and pointing out interactions when there is a slackening of activity in the group.
3. Posing pointed questions to facilitate participation.
4. Dealing with individual and group resistances.
5. Supporting upset members.
6. Encouraging withdrawn members to talk.
7. Interfering with hostile pairings who upset the group with their quarrelling.
8. Reminding the group that communication about and understanding of mutual relationships is more important than interpreting dynamics.
9. Managing silence, which tends to mobilize tension in the group.

GROUP APPROACHES

Pre intake and Post intake Groups

Pre intake groups, which act as a forum for discussion and orientation, are a valuable aspect of clinic functioning where a delay is unavoidable before formal intake. Up to 20 people may attend, and sessions may be given at weekly, bimonthly, and even monthly intervals. Parents of children awaiting intake may be organized into a group of this type, which may meet for 3 to 6 monthly sessions. Post intake groups may take place before permanent assignment, and meetings may be spaced weekly or up to 1 month apart. Here some therapeutic changes are possible as disturbing problems are introduced and elaborated. These preliminary groups serve as useful means of selecting patients for on-going group therapy. They are worthy orientation and psycho education devices and help prepare and motivate patients for therapy.

Special Age Groups

Group therapy with children is usually of an activity nature. The size of children's groups must be kept below that of adult groups. For instance, in the age group up to 6 years, two or three children constitute the total. Both boys and girls can be included. Single-sex groups are
(1) from 6 to 8 years, which optimally consist of three to five members;
(2) from 8 to 12 years, which may have four to six members;
(3) from 12 to 14 years, which may contain six to eight youngsters; and
(4) from 14 to 16 years, which have the same number. Mixed-sex groups at the oldest age level are sometimes possible.

Play therapy is the communicative medium up to 12 years of age, the focus being on feelings and conflicts. It is obvious that the ability to communicate is a prerequisite here. Beyond 12 years discussions rather than play constitute the best activity medium. Techniques include analysis of behaviour in the group, confrontation, and dream and transference interpretation. Both activity

(during which acting-out may be observed) and discussion take place at various intervals. Interventions of the therapist should be such so as not to hamper spontaneity. Discussion is stimulated by the therapist, and silences are always interrupted. Ideally, individual therapy is carried on conjointly with group therapy, particularly at the beginning of treatment. Group psychotherapy with older people has met with considerable success in maintaining interest and alertness, managing depression, promoting social integration, and enhancing the concept of self in both affective and organic disorders. Where the goal is reconstructive, oldsters may be mixed with younger people.

Behaviour Therapy in Groups

Behavioural techniques lend themselves admirably to group usage, and results, as well as controlled studies, indicate that behavioural change may be achieved by the employment of methods such as behavioural rehearsal, modelling, discrimination learning, and social reinforcement. The group process itself tends to accelerate behavioural strategies. Homogeneous groups seem to do best, the selection of members being restricted to those who may benefit from the retraining of specific target behaviours. Thus, the control of obesity, shyness, speaking anxiety, insomnia, and phobias (flying insects, mice, closed spaces, etc.) can best be achieved in a group where the participants are focused on the abolition of similar undesirable behaviours.

The Curative Factors

Yalom (1975) has specified a set of *curative factors* that seems to define the essence of what these group methods offer:

1. *Imparting information*. Group members can receive advice and guidance not just from the therapist but also from other group members.

2. *Instilling hope*. Observing others who have successfully grappled with problems helps to instill hope—a necessary ingredient for any successful therapy experience.

3. *Universality*. Listening to others, one discovers that he or she has the same problems, fears, and concerns. Knowing that one is not alone can be highly rewarding.

4. *Altruism*. In the beginning, a group member often feels useless and demoralized. As it becomes apparent that one can help others in the group, a feeling of greater self-value and competence emerges.

5. *Interpersonal learning*. Interacting with others in the group can teach one about interpersonal relationships, social skills, sensitivity to others, resolution of conflicts, and so on.

6. *Imitative behaviour*. Watching and listening to others can lead to the modelling of more useful behaviours. Group members learn from one another.

7. *Corrective recapitulation of the primary family*. The group context can help clients understand and resolve problems related to family members. The effects of past family experiences can be

dissolved by learning that maladaptive coping methods will not work in the present group situation.

8. *Catharsis*. Learning how to express feelings about others in the group in an honest, open way builds a capacity for mutual trust and understanding.

9. *Group cohesiveness*. Group members become a tightly knit little group that enhances self-esteem through group acceptance.