# UNIT 2 FAMILY AND GROUP PSYCHOTHERAPY

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## 2.0 INTRODUCTION

Family therapy, also referred to as couple and family therapy and family systems therapy, is a branch of psychotherapy that works with families and couples in intimate relationships to nurture change and development. It tends to view change in terms of the systems of interaction between family members. It emphasises family relationships as an important factor in psychological health.

The different schools of family therapy have in common, a belief, that regardless of the origin of the problem, and regardless of whether the clients consider it an

"individual" or "family" issue, involving families in solutions is often beneficial. This involvement of families is commonly accomplished by their direct participation in the therapy session. The skills of the family therapist thus include the ability to influence conversations in a way that catalyses the strengths, wisdom, and support of the wider system.

In early years of the development of the field, many clinicians defined the family in a narrow, traditional manner usually including parents and children. As the field has evolved, the concept of the family is more commonly defined in terms of strongly supportive, long-term roles and relationships between people who may or may not be related by blood or marriage.

Family therapy has been used effectively in the full range of human dilemmas. There is no category of relationship or psychological problem that has not been addressed with this approach. The conceptual frameworks developed by family therapists, especially those of family systems theorists, have been applied to a wide range of human behaviour, including organisational dynamics. In this unit we will be dealing with family and group therapy. We will trace the historical framework of family therapy, present the techniques of family therapy and discuss the various techniques of family therapy. We then deal with models of family therapy and delve deeply into group psychotherapy.

## 2.1 OBJECTIVES

After reading this unit, you will be able to:

- Understand the following aspects related to family and group psychotherapy:
- History and Theoretical Frameworks of Family Therapy;
- Techniques of Family Therapy;
- Models of Family Therapy;
- History of Group Psychotherapy; and
- Therapeutic principles and settings.

## 2.2 NATURE AND DEFINITION OF FAMILY THERAPY

Family therapy refers to the joint treatment of two or more members of the same family in order to change unhealthy patterns of communication and interaction. Family therapy is generally initiated because of psychological or emotional problems experienced by a single family member, often a child or adolescent. These problems are treated as symptomatic of dysfunction within the family system as a whole. The therapist focuses on the interaction between family members, analysing the role played by each member in maintaining the system. Family therapy can be especially helpful for dealing with problems that develop in response to a particular event or situation, such as divorce or remarriage, or the birth of a new sibling. It can also be an effective means to draw individuals who feel threatened by individual therapy into a therapeutic setting.

### 2.2.1 History and Theoretical Frameworks of Family Therapy

Formal interventions with families to help individuals and families experiencing various kinds of problems have been a part of many cultures, probably throughout history. These interventions have sometimes involved formal procedures or rituals, and often included the extended family as well as non-kin members of the community. These interventions were often conducted by particular members of a community – for example, a chief, priest, physician and so on – usually as an ancillary function.

*Family therapy* as a distinct professional practice had its origins in the social work movements of the 19th century in England and the United States. As a branch of psychotherapy, its roots can be traced somewhat later to the early 20th century with the emergence of the *child guidance* movement and *marriage counseling*. The formal development of family therapy dates to the 1940s and early 1950s with the founding in 1942 of the *American Association of Marriage Counselors* and through the work of various independent clinicians and groups – in England (John Bowlby), the US (John Bell, Nathan Ackerman, Christian Midelfort, Theodore Lidz, Lyman Wynne, Murray Bowen, Carl Whitaker, Virginia Satir), and Hungary (D.L.P. Liebermann) – who began seeing family members together for observation or therapy sessions. There was initially a strong influence from psychoanalysis (most of the early founders of the field had psychoanalytic backgrounds) and social psychiatry, and later from learning theory and behaviour therapy – and significantly, these clinicians began to articulate various theories about the nature and functioning of the family as an entity that was more than a mere aggregation of individuals.

The movement received an important boost in the mid-1950s through the work of anthropologist Gregory Bateson and colleagues – Jay Haley, Donald D. Jackson, John Weakland, William Fry, and later, Virginia Satir, Paul Watzlawick and others – at Palo Alto in the US, who introduced ideas from cybernetics and general systems theory into social psychology and psychotherapy, focusing in particular on the role of communication.

This group was also influenced significantly by the work of US psychiatrist, hypnotherapist, and brief therapist, Milton H. Erickson - especially his innovative use of strategies for change, such as *paradoxical directives*. The members of the Bateson Project had a particular interest in the possible psychosocial causes and treatment of schizophrenia, especially in terms of the putative "meaning" and "function" of signs and symptoms within the family system.

The research of psychiatrists and psychoanalysts Lyman Wynne and Theodore Lidz on *communication deviance* and *roles* (e.g., *pseudo-mutuality*, *pseudo-hostility*, *schism* and *skew*) in families of also became influential with *systems-communications*-oriented theorists and therapists. A related theme, applying to dysfunction and psychopathology more generally, was that of the "identified patient" or *"presenting problem"* as a manifestation of or surrogate for the family's or even society's problems.

By the mid-1960s a number of distinct schools of family therapy had emerged. From those groups that were most strongly influenced by cybernetics and systems theory, there came MRI Brief Therapy, and slightly later, strategic therapy, Salvador Minuchin's *Structural Family Therapy* and the Milan systems model.

Partly in reaction to some aspects of these *systemic* models, came the *experiential* approaches of Virginia Satir and Carl Whitaker, which downplayed theoretical constructs, and emphasised subjective experience and unexpressed feelings (including the subconscious), authentic communication, spontaneity, creativity, total therapist engagement, and often included the extended family.

Concurrently and somewhat independently, there emerged the various *intergenerational* therapies of Murray Bowen, Ivan Böszörményi-Nagy, James Framo, and Norman Paul, which present different theories about the intergenerational transmission of health and dysfunction, but which all deal usually with at least three generations of a family either directly in therapy sessions, or via *"homework"*, *"journeys home"*, etc.

**Psychodynamic Family Therapy**

This, more than any other school of family therapy, deals directly with individual psychology and the unconscious in the context of current relationships - continued to develop through a number of groups that were influenced by the ideas and methods of Nathan Ackerman, and also by the *British School* of Object Relations and John Bowlby's work on attachment.

**Multiple-Family Group Therapy**

This is a precursor of *psychoeducational family intervention*, emerged, in part, as a pragmatic alternative form of intervention – especially as an adjunct to the treatment of serious mental disorders with a significant biological basis, such as schizophrenia - and represented something of a conceptual challenge to some of the *"systemic"* (and thus potentially "family-blaming") paradigms of pathogenesis that were implicit in many of the dominant models of family therapy.

The late-1960s and early-1970s saw the development of *network therapy* by Ross Speck and Carolyn Attneave, and the emergence of *behavioural marital therapy* (renamed *behavioural couples therapy* in the 1990s) and *behavioural family therapy* as models in their own right.

By the late-1970s the weight of clinical experience – especially in relation to the treatment of serious mental disorders – had led to some revision of a number of the original models and a moderation of some of the earlier stridency and theoretical purism.

There were the beginnings of a general softening of the strict demarcations between schools, with moves toward rapprochement, integration, and eclecticism – although there was, nevertheless, some hardening of positions within some schools. However, there was a growing willingness and tendency on the part of family therapists to work in multi-modal clinical partnerships with other members of the helping and medical professions.

From the mid-1980s to the present, the field has been marked by a diversity of approaches that partly reflect the original schools, but which also draw on other theories and methods from individual psychotherapy. These approaches and sources include brief therapy, structural therapy, constructivist approaches (e.g., Milan systems, *post-Milan/collaborative/conversational*, *reflective*), solution-focused therapy, narrative therapy, a range of cognitive and behavioural approaches, psychodynamic and object relations approaches, attachment and

Emotionally Focused Therapy, *intergenerational* approaches, *network therapy*, and multisystemic therapy (MST). Multicultural, intercultural, and integrative approaches are also being developed.

Many practitioners claim to be "eclectic," using techniques from several areas, depending upon their own inclinations and/or the needs of the client(s), and there is a growing movement toward a single "generic" family therapy that seeks to incorporate the best of the accumulated knowledge in the field and which can be adapted to many different contexts. However, there are still a significant number of therapists who adhere more or less strictly to a particular or limited number of approaches.

### 2.2.2 Techniques of Family Therapy

Family therapy uses a range of counseling and other techniques including:

- communication theory
- media and communications psychology
- psychoeducation
- psychotherapy
- relationship education
- systemic coaching
- systems theory
- reality therapy

The number of sessions depends on the situation, but the average is 5-20 sessions. A family therapist usually meets several members of the family at the same time. This has the advantage of making differences between the ways family members perceive mutual relations as well as interaction patterns in the session apparent both for the therapist and the family.

These patterns frequently mirror habitual interaction patterns at home, even though the therapist is now incorporated into the family system. Therapy interventions usually focus on relationship patterns rather than on analysing impulses of the unconscious mind or early childhood trauma of individuals as a Freudian therapist would do - although some schools of family therapy, for example *psychodynamic* and *intergenerational*, do consider such individual and historical factors (thus embracing both *linear* and *circular* causation) and they may use instruments such as the genogram to help to elucidate the patterns of relationship across generations.

The distinctive feature of family therapy is its perspective and analytical framework rather than the number of people present at a therapy session. Specifically, family therapists are relational therapists. They are generally more interested in what goes on *between* individuals rather than *within* one or more individuals, although some family therapists—in particular those who identify as psychodynamic, object relations, *intergenerational*, EFT, or *experiential* family therapists—tend to be as interested in individuals as in the *systems* those individuals and their relationships constitute. Depending on the conflicts at issue and the progress of therapy to date, a therapist may focus on analysing specific previous instances of conflict, as by reviewing a past incident and suggesting

alternative ways family members might have responded to one another during it, or instead proceed directly to addressing the sources of conflict at a more abstract level, as by pointing out patterns of interaction that the family might have not noticed.

Family therapists tend to be more interested in the maintenance and/or solving of problems rather than in trying to identify a single cause. Some families may perceive cause-effect analyses as attempts to allocate blame to one or more individuals, with the effect that for many families a focus on causation is of little or no clinical utility.

### 2.2.3 Values and Ethics in Family Therapy

Since issues of interpersonal conflict, power, control, values, and ethics are often more pronounced in relationship therapy than in individual therapy, there has been debate within the profession about the different values that are implicit in the various theoretical models of therapy and the role of the therapist's own values in the therapeutic process, and how prospective clients should best go about finding a therapist whose values and objectives are most consistent with their own. Specific issues that have emerged have included an increasing questioning of the longstanding notion of *therapeutic neutrality*, a concern with questions of justice and self-determination, connectedness and independence, "functioning" versus "authenticity", and questions about the degree of the therapist's "pro-marriage/family" versus "pro-individual" commitment.

**Self Assessment Questions**

1) Explain the concept of family therapy.

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2) Discuss the theoretical frameworks of family therapy.

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### 2.2.4 Models of Family Therapy

There are many models of family therapy and these are presented in the table below.

**Models of Family Therapy**

| Theoretical Model | Theorists | Summary | Techniques |
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| Adlerian Family Therapy | Alfred Adler | Also known as "Individual Psychology". Sees the person as a whole. Ideas include compensation for feelings of inferiority leading to striving for significance toward a fictional final goal with a private logic. Birth order and mistaken goals are explored to examine mistaken motivations of children and adults in the family constellation. | Psychoanalysis, Typical Day, Reorienting, Re-educating |
| Attachment Theory | John Bowlby, Mary Ainsworth | Individuals are shaped by their experiences with caregivers in the first three years of life. Used as a foundation for Object Relations Theory. The Strange Situation experiment with infants involves a systematic process of leaving a child alone in a room in order to assess the quality of their parental bond. | Psychoanalysis, Play Therapy |
| Bowenian Family Systems | Murray Bowen, Betty Carter, Philip Guerin, Michael Kerr, Thomas Fogarty, Monica McGoldrick, Edwin Friedman, Daniel Papero | Also known as "Intergenerational Family Therapy" (although there are also other schools of intergenerational family therapy). Family members are driven to achieve a balance of internal and external differentiation, causing anxiety, triangulation, and emotional cut-off. Families are affected by nuclear family emotional processes, sibling positions and multigenerational transmission patterns resulting in an undifferentiated family ego mass. | Detriangulation, Nonanxious Presence, Genograms, Coaching |
| Cognitive Behavioural Family Therapy | John Gottman, Albert Ellis, Albert Bandura | Problems are the result of operant conditioning that reinforces negative behaviours within the family's interpersonal social exchanges that extinguish desired behaviour and promote incentives toward unwanted behaviours. This can lead to irrational beliefs and a faulty family schema. | Therapeutic Contracts, Modelling, Systematic Desensitisation, Shaping, Charting, Examining Irrational Beliefs |
| Collaborative Language Systems | Harry Goolishian, Harlene Anderson, Tom Andersen, Lynn Hoffman, | Individuals form meanings about their experiences within the context of social relationship on a personal and organisational level. Collaborative therapists help families reorganise and dissolve their perceived problems through a transparent dialogue about inner thoughts with a "not-knowing" stance intended to illicit new meaning through | Dialogical Conversation, Not Knowing, Curiosity, Being Public, Reflecting Teams |

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| | Peggy Penn | conversation. Collaborative therapy is an approach that avoids a particular theoretical perspective in favour of a client-centered philosophical process. | |
| Communications Approaches | Virginia Satir, John Banmen, Jane Gerber, Maria Gomori | All people are born into a primary survival triad between themselves and their parents where they adopt survival stances to protect their self-worth from threats communicated by words and behaviours of their family members. Experiential therapists are interested in altering the overt and covert messages between family members that affect their body, mind and feelings in order to promote congruence and to validate each person's inherent self-worth. | Equality, Modeling Communication, Family Life Chronology, Family Sculpting, Metaphors, Family Reconstruction |
| Contextual Therapy | Ivan Boszormenyi Nagy | Families are built upon an unconscious network of implicit loyalties between parents and children that can be damaged when these "relational ethics" of fairness, trust, entitlement, mutuality and merit are breached. | Rebalancing, Family Negotiations, Validation, Filial Debt Repayment |
| Emotion-Focused Therapy | Sue Johnson, Les Greenberg | Couples and families can develop rigid patterns of interaction based on powerful emotional experiences that hinder emotional engagement and trust. Treatment aims to enhance empathic capabilities of family members by exploring deep-seated habits and modifying emotional cues. | Reflecting, Validation, Heightening, Reframing, Restructuring |
| Experiential Family Therapy | Carl Whitaker, David Kieth, Laura Roberto, Walter Kempler, John Warkentin, Thomas Malone, August Napier | Stemming from Gestalt foundations, change and growth occurs through an existential encounter with a therapist who is intentionally "real" and authentic with clients without pretense, often in a playful and sometimes absurd way as a means to foster flexibility in the family and promote individuation. | Battling, Constructive Anxiety, Redefining Symptoms, Affective Confrontation, Co-Therapy, Humor |
| Feminist Family Therapy | Sandra Bern, | Complications from social and political disparity between genders are identified as underlying causes of conflict within a family system. Therapists are encouraged to be aware of these influences in order to avoid perpetuating hidden oppression, biases and cultural stereotypes and to model an egalitarian perspective of healthy family relationships. | Demystifying, Modeling, Equality, Personal Accountability |

| Milan Systemic Family Therapy | Luigi Boscolo, Gianfranco Cecchin, Mara Selvini Palazzoli, Giuliana Prata | A practical attempt by the "Milan Group" to establish therapeutic techniques based on Gregory Bateson's cybernetics that disrupts unseen systemic patterns of control and games between family members by challenging erroneous family beliefs and reworking the family's linguistic assumptions. | Hypothesising, Circular Questioning, Neutrality, Counterparadox |
|---|---|---|---|
| Medical Family Therapy | Goerge Engel, Susan McDaniel, Jeri Hepworth & William Doherty | Families facing the challenges of major illness experience a unique set of biological, psychological and social difficulties that require a specialised skills of a therapist who understands the complexities of the medical system, as well as the full spectrum of mental health theories and techniques. | Grief Work, Family Meetings, Consultations, Collaborative Approaches |
| MRI Brief Therapy | Gregory Bateson, , Heinz von Foerster | Established by the Mental Research Institute (MRI) as a synthesis of ideas from multiple theorists in order to interrupt misguided attempts by families to create first and second order change by persisting with "more of the same," mixed signals from unclear metacommunication and paradoxical double-bind messages. | Reframing, Prescribing the Symptom, Relabeling, Restraining (Going Slow), Bellac Ploy |
| Narrative Therapy | Michael White, David Epston | People use stories to make sense of their experience and to establish their identity as a social and political constructs based on local knowledge. Narrative therapists avoid marginalising their clients by positioning themselves as a co-editor of their reality with the idea that "the person is not the problem, but the problem is the problem." | Deconstruction, Externalising Problems, Mapping, Asking Permission |
| Object Relations Therapy | Hazan & Shaver, David Scharff & Jill Scharff, James Framo, | Individuals choose relationships that attempt to heal insecure attachments from childhood. Negative patterns established by their parents (object) are projected onto their partners. | Detriangulation, Co-Therapy, Psychoanalysis, Holding Environment |
| Psychoanalytic Family Therapy | Nathan Ackerman | By applying the strategies of Freudian psychoanalysis to the family system therapists can gain insight into the interlocking psychopathologies of the family members and seek to improve complementarity | Psychoanalysis, Authenticity, Joining, Confrontation |
| Solution Focused Therapy | Kim Insoo Berg, Steve de Shazer, William O'Hanlon, Michelle Weiner-Davis, Paul Watzlawick | The inevitable onset of constant change leads to negative interpretations of the past and language that shapes the meaning of an individual's situation, diminishing their hope and causing them to overlook their own strengths and resources. | Future Focus, Beginner's Mind, Miracle Question, Goal Setting, Scaling |

| Strategic Therapy | Jay Haley, Cloe Madanes | Symptoms of dysfunction are purposeful in maintaining homeostasis in the family hierarchy as it transitions through various stages in the family life cycle. | Directives, Paradoxical Injunctions, Positioning, Metaphoric Tasks, Restraining (Going Slow) |
|---|---|---|---|
| Structural Therapy | Salvador Minuchin, Harry Aponte, Charles Fishman, Braulio Montalvo | Family problems arise from maladaptive boundaries and subsystems that are created within the overall family system of rules and rituals that governs their interactions. | Joining, Family Mapping, Hypothesising, Reenactments, Reframing, Unbalancing |

## 2.3 GROUP PSYCHOTHERAPY

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 refer to any form of psychotherapy when delivered in a group format, including 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.

The broader concept of *group therapy* refers to any helping process that takes place in a group, including support groups, skills training groups (such as anger management, mindfulness, relaxation training or social skills training), and psycho-education groups. The differences between psychodynamic groups, activity groups, support groups, problem-solving and psycoeducational groups are discussed by Montgomery (2002). Other, more specialised forms of group therapy would include non-verbal expressive therapies such as dance therapy, music therapy or the TaKeTiNa Rhythm Process.

### 2.3.1 Group Therapy Vs. Individual Therapy

Group therapy is different from individual therapy in a number of ways, with the most obvious difference being the number of people in the room with the psychologist. Originally, group therapy was used as a cost-saving measure, in institutional settings where many people needed psychological treatment and there were too few psychologists to provide the treatment. However, in conducting research on the effectiveness of these therapy groups, psychologists discovered that the group experience benefited people in many ways that were not always addressed in individual psychotherapy. Likewise, it was also discovered that some people did not benefit from group therapy.

The aim of group psychotherapy is to help with solving the emotional difficulties and to encourage the personal development of the participants in the group. The therapist (called conductor, leader or facilitator) chooses as candidates for the group people who can benefit from this kind of therapy and those who may have a useful influence on other members in the group.

### 2.3.2 History of Group Psychotherapy

The founders of group psychotherapy in the USA were Joseph H. Pratt, Trigant Burrow and Paul Schilder. After World War II group psychotherapy was further developed by Jacob L. Moreno, Samuel Slavson, Hyman Spotnitz, Irvin Yalom, and Lou Ormont. Yalom's approach to group therapy has been very influential not only in the USA but across the world, through his classic text *"The Theory and Practice of Group Psychotherapy"*. Moreno developed a specific and highly structured form of group therapy known as Psychodrama.

In the United Kingdom group psychotherapy initially developed independently, with pioneers S. H. Foulkes and Wilfred Bion using group therapy as an approach to treating combat fatigue in the Second World War. Foulkes and Bion were psychoanalysts and incorporated psychoanalysis into group therapy by recognising that transference can arise not only between group members and the therapist but also among group members. Furthermore the psychoanalytic concept of the unconscious was extended with recognition of a group unconscious, in which the unconscious processes of group members could be acted out in the form of irrational processes in group sessions.

### 2.3.3 Therapeutic Principles

Yalom's therapeutic factors (originally termed *curative factors)* are derived from extensive self-report research with users of group therapy.

**Universality:** The recognition of shared experiences and feelings among group members and that these may be widespread or universal human concerns, serves to remove a group member's sense of isolation, validate their experiences, and raise self-esteem.

**Altruism:** The group is a place where members can help each other, and the experience of being able to give something to another person can lift the member's self esteem and help develop more adaptive coping styles and interpersonal skills.

**Instillation of hope:** In a mixed group that has members at various stages of development or recovery, a member can be inspired and encouraged by another member who has overcome the problems with which they are still struggling.

**Imparting information:** While this is not strictly speaking a psychotherapeutic process, members often report that it has been very helpful to learn factual information from other members in the group. For example, about their treatment or about access to services.

**Corrective recapitulation of the primary family experience:** Members often unconsciously identify the group therapist and other group members with their own parents and siblings in a process that is a form of transference specific to group psychotherapy. The therapist's interpretations can help group members gain understanding of the impact of childhood experiences on their personality, and they may learn to avoid unconsciously repeating unhelpful past interactive patterns in present-day relationships.

**Development of socialising techniques:** The group setting provides a safe and supportive environment for members to take risks by extending their repertoire of interpersonal behaviour and improving their social skills.

**Imitative behaviour:** One way in which group members can develop social skills is through a modeling process, observing and imitating the therapist and other group members. For example, sharing personal feelings, showing concern, and supporting others.

**Cohesiveness:** It has been suggested that this is the primary therapeutic factor from which all others flow. Humans are herd animals with an instinctive need to belong to groups, and personal development can only take place in an interpersonal context. A cohesive group is one in which all members feel a sense of belonging, acceptance, and validation.

**Existential factors:** It refers to the learning that one has to take responsibility for one's own life and the consequences of one's decisions.

**Catharsis:** Catharsis is the experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt.

**Interpersonal learning:** Group members achieve a greater level of self-awareness through the process of interacting with others in the group, who give feedback on the member's behaviour and impact on others.

**Self-understanding:** This factor overlaps with interpersonal learning but refers to the achievement of greater levels of insight into the genesis of one's problems and the unconscious motivations that underlie one's behaviour.

### 2.3.4 Settings

Group therapy can form part of the therapeutic milieu of a psychiatric in-patient unit. In addition to classical "talking" therapy, group therapy in an institutional setting can also include group-based expressive therapies such as drama therapy, psychodrama, art therapy, and non-verbal types of therapy such as music therapy. Group psychotherapy is a key component of Milieu Therapy in a Therapeutic Community. The total environment or milieu is regarded as the medium of therapy, all interactions and activities regarded as potentially therapeutic and are subject to exploration and interpretation, and are explored in daily or weekly community meetings.

In group therapy approximately 6-10 individuals meet face-to-face with a trained group therapist. During the group meeting time, members decide what they want to talk about.

Members are encouraged to give feedback to others. Feedback includes expressing your own feelings about what someone says or does. Interaction between group members are highly encouraged and provides each person with an opportunity to try out new ways of behaving; it also provides members with an opportunity for learning more about the way they interact with others. It is a safe environment in which members work to establish a level of trust that allows them to talk personally and honestly. Group members make a commitment to the group and are instructed that the content of the group sessions are confidential. It is not appropriate for group members to disclose events of the group to an outside person.

### 2.3.5 Construction of Therapy Groups

Therapy groups may be homogeneous or heterogeneous. Homogeneous groups have members with similar diagnostic backgrounds (for example, they may all suffer from depression). Heterogeneous groups contain a mix of individuals with different emotional problems. The number of group members typically ranges from five to 12.

### 2.3.6 Functioning of Therapy Groups

The number of sessions in group therapy depends upon the group's makeup, goals, and setting. Some are time limited, with a predetermined number of sessions known to all members at the beginning. Others are indeterminate, and the group and/or therapist determine when the group is ready to disband. Membership may be closed or open to new members. The therapeutic approach used depends on both the focus of the group and the therapist's orientation.

In group therapy sessions, members are encouraged to discuss the issues that brought them into therapy openly and honestly. The therapist works to create an atmosphere of trust and acceptance that encourages members to support one another. Ground rules may be set at the beginning, such as maintaining confidentiality of group discussions, and restricting social contact among members outside the group.

The therapist facilitates the group process, that is, the effective functioning of the group, and guides individuals in self-discovery. Depending upon the group's goals and the therapist's orientation, sessions may be either highly structured or fluid and relatively undirected. Typically, the leader steers a middle course, providing direction when the group gets off track, yet letting members set their own agenda. The therapist may guide the group by reinforcing the positive behaviours they engage in. For example, if one member shows empathy and supportive listening to another, the therapist might compliment that member and explain the value of that behaviour to the group. In almost all group therapy situations, the therapist will emphasise the commonalities among members to instill a sense of group identity.

Self-help or support groups like Alcoholics Anonymous and Weight Watchers fall outside of the psychotherapy realm. These groups offer many of the same benefits, including social support, the opportunity to identify with others, and the sense of belonging that makes group therapy effective for many. Self-help groups also meet to share their common concern and help one another cope. These groups, however, are typically leaderless or run by a member who takes on the leader role for one or more meetings. Sometimes self-help groups can be an adjunct to psychotherapy groups.

### 2.3.7 Referral of Patients to Group Therapy

Individuals are typically referred for group therapy by a psychologist or psychiatrist. Some may participate in both individual and group therapy. Before a person begins in a therapy group, the leader interviews the individual to ensure a good fit between their needs and the group's. The individual may be given some preliminary information before sessions begin, such as guidelines and ground rules, and information about the problem on which the group is focused.

### 2.3.8 Termination of Therapy Groups

Therapy groups end in a variety of ways. Some, such as those in drug rehabilitation programs and psychiatric hospitals, may be ongoing, with patients coming and going as they leave the facility. Others may have an end date set from the outset. Still others may continue until the group and/or the therapist believe the group goals have been met.

The termination of a long-term therapy group may cause feelings of grief, loss, abandonment, anger, or rejection in some members. The therapist attempts to deal with these feelings and foster a sense of closure by encouraging exploration of feelings and use of newly acquired coping techniques for handling them. Working through this termination phase is an important part of the treatment process.

### 2.3.9 Drop Outs of Group Therapy

Individuals who are emotionally fragile or unable to tolerate aggressive or hostile comments from other members are at risk of dropping out, as are those who have trouble communicating in a group setting. If the therapist does not support them and help reduce their sense of isolation and aloneness, they may drop out and feel like failures. The group can be injured by the premature departure of any of its members, and it is up to the therapist to minimize the likelihood of this occurrence by careful selection and management of the group process.

### 2.3.10 Effectiveness

Studies have shown that both group and individual psychotherapy benefit about 85% of the patients who participate in them. Ideally, patients leave with a better understanding and acceptance of themselves, and stronger interpersonal and coping skills. Some individuals continue in therapy after the group disbands, either individually or in another group setting.

**Self Assessment Questions**

1) Explain any two models of family therapy.

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2) Discuss theoretical principles of group therapy.

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## 2.4 ADVANTAGES OF GROUP THERAPY

1) When people come into a group and interact freely with other group members, they usually recreate those difficulties that brought them to group therapy in the first place. Under the direction of the group therapist, the group is able to give support, offer alternatives, and comfort members in such a way that these difficulties become resolved and alternative behaviours are learned.

2) The group also allows a person to develop new ways of relating to people.

3) During group therapy, people begin to see that they are not alone and that there is hope and help. It is comforting to hear that other people have a similar difficulty, or have already worked through a problem that deeply disturbs another group member.

4) Another reason for the success of group therapy is that people feel free to care about each other because of the climate of trust in a group.

## 2.5 TYPES OF GROUPS

There are many kinds of groups in the group-psychotherapy field. The techniques used in group therapy can be verbal, expressive, psycho dramatic etc. The approaches can vary from psychoanalytic to behavioural, Gestalt or encounter groups. Groups vary from classic psychotherapy groups, where process is emphasised, to psycho educational, which are closer to a class. Psycho educational groups usually focus on the most common areas of concern, notably relationships, anger, stress-management etc. They are frequently more time-limited (10 to 15 sessions) and thus very appealing in a managed care environment.Each approach has its advantages and drawbacks, and the participant should consult the expert which technique matches her/his unique personality. Some unique groups are:

### 2.5.1 T-Groups

These groups are training groups. These are relatively unstructured groups in which the participants become responsible for what they learn and how they learn it. A basic assumption appropriate to T- groups is that learning is more effective when the individual establishes authentic relationships with others.

### 2.5.2 Sensitivity Groups

It is a form of T-group that focuses on personal and interpersonal issues and on the personal growth of the individual. There is an emphasis in sensitivity groups on self – insight, which means that the central focus is not the group and its progress but, the individual member.

### 2.5.3 Encounter Groups

These groups are also in the T- group family, although they are more therapy oriented. This group stresses personal growth through the development and improvement of interpersonal relationships through an experiential group processes. Such groups seek to release the potential of the participant.

### 2.5.4 Marathon Groups

Extended encounter groups are often referred to as marathon groups. The marathon encounter group uses an extended block of time in which massed experience and accompanying fatigue are used to break through the participant's defenses. Though these groups offer great potential for the group members increased self – awareness and sensitivity to others, such groups can create high levels of anxiety and frustration. Therefore, it is essential that if encounter groups are to have maximum potential and minimal risk, they must be conducted by highly skilled and experienced counsellor leaders.

### 2.5.5 Task Groups

These groups are organised to meet organisational needs through task forces or other organisational groups or to serve individual needs of clients through such activities as social action groups. These groups are frequently useful to organisations seeking ways to improve their functioning. Task groups may be organised to assist clients in dealing with a wide range of needs from spiritual to educational.

### 2.5.6 Psycho Education Groups

These emphasise cognitive and behavioural skill development in groups structured to teach these skills and knowledge. These groups are more guidance in nature than counselling or therapy oriented.

### 2.5.7 Mini Groups

A minigroup usually consists of one counsellor and a maximum of four clients. Because of the smaller number of participants, the potential exists for certain advantages resulting from the more frequent and direct interaction of its members. Withdrawal by individuals and the development of factions or cliques are less likely in minigroups.

### 2.5.8 In Groups and Out Groups

These groups can be based on almost any criteria such as socioeconomic status, athletic or artistic accomplishments, a particular ability, etc. In-groups are characterised by associations largely limited with peers of like characteristics where as out groups consist of those excluded from in groups.

Social Networks: These result from the choices that individuals make in becoming members of various groups. As counsellors, we may be concerned with how these choices are made and their impacts on individuals.

## 2.6 LET US SUM UP

Family therapy has a variety of origins. It is related to the long-standing emphasis of psychoanalysis and other psychodynamic approaches on the central role that early family relationships play in the formation of personality and the manifestation of psychological disorders.

Family therapy, either alone or in conjunction with other types of treatment, has been effective in the treatment of children suffering from a variety of problems,

including anxiety, enuresis (bed-wetting), and eating disorders, and also in working with victims of child abuse. In addition to alleviating the child's initial complaint and improving communication within the family unit, family therapy can also help reduce stress and conflict by helping families improve their coping skills.

There are a number of approaches to family therapy. Perhaps the best known is structural family therapy, founded by Salvador Minuchin. It is a short-term method that focuses on the present rather than the past. This school of therapy views a family's behaviour patterns and rituals as central to the problems of its individual members. Poor communication skills play a key role in perpetuating destructive interactions within families, such as the formation of alliances among some family members against others. The goals of structural family therapy include strengthening parental leadership, clarifying boundaries, enhancing coping skills, and freeing family members from their entrenched positions within the family structure. Minuchin divided families' styles of interacting into two basic types—enmeshed and disengaged, considering behaviour at either extreme as pathological, with most families falling somewhere on a continuum between the two. Minuchin believed that the functioning of family systems prevented individuals from becoming healthier emotionally, because the family system relied on its troubled member to play a particular role in order to function in its accustomed way. This stability is disrupted if an individual changes significantly.

Psychodynamically oriented family therapy emphasises unconscious processes and unresolved conflicts in the parents' families of origin. The lasting effects of such traumatic experiences as parental divorce and child abuse are explored. This type of therapy focuses more on family history and less on symptoms, resulting in a lengthier therapeutic process. Therapists who employ an object relations approach emphasise the importance of having the parents in a family work out conflicts with their own parents. Some practitioners include grandparents in their work with families in order to better understand intergenerational dynamics and deeply rooted behaviour patterns. Ivan Boszormenyi-Nagy, a well-known proponent of this orientation, would only treat families when members of three generations could participate in therapy sessions.

Behavioural family therapy views interactions within the family as a set of behaviours that are either rewarded or punished. The behavioural therapist educates family members to respond to each others' behaviour with positive or negative reinforcement. A child might be discouraged from repeating a negative behaviour, for example, by losing some privileges or receiving a "time-out." Positive behaviour might be rewarded with the use of an incentive chart on which points or stickers are accrued and eventually exchanged for a reward. Behavioural approaches sometimes involve the drawing up of behavioural "contracts" by family members, as well as the establishment of rules and reinforcement procedures.

Several other family therapy approaches, including that of Virginia Satir, are primarily concerned with communication. Satir's system combines the teaching of family communication skills, the promotion of self-esteem and the removal of obstacles to the emotional growth so that family members can have full access to their innate resources.

Group therapy is a type of psychotherapy that involves one or more therapists working with several people at the same time. Group therapy sessions generally involve around seven to twelve individuals. The group typically meets once or twice each week for an hour or two. The minimum number of group therapy sessions is usually around six, but a full year of sessions is more common.

The specific manner in which the session is conducted depends largely on the goals of the group and the style of the therapist. Some therapists might encourage a more free-form style of dialogue, where each member participates as he or she sees fit. Other therapists might have a specific plan for each session that might include having clients practice new skills with other members of the group.

There are various types of group therapy; approaches include behaviour therapy, psychoanalytic therapy, sensitivity training, or Gestalt psychology. The composition of groups varies as well, with family therapy and marriage counseling common forms in recent years. Peer group therapy usually consists of a group of individuals who have similar problems, and can be mediated by a psychoanalyst or by the members themselves.

## 2.7 UNIT END QUESTIONS

1) Discuss different models of family therapy.
2) Explain the process of group psychotherapy.
3) What are the advantages of group therapy?

## 2.8 SUGGESTED READINGS

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