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Intentions, Objectives and Profits of Group Therapy

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Abstract: Groups practiced in a therapeutic aim are often organized according to a certain type of activity. Theoretical reflection nourishes practice. Some were initiated at the end of World War II, for instance the so called "Institutional Psychotherapy". This gave birth to different approaches practiced in some psychiatric institutions, then in various associations meant to improve practices in mental health. Other approaches are of educational aim, of which psycho-education, cognitive remediation, therapeutic education. The author initiated a method of speech group that can go to various publics, as much to patients as to family members or to those who want to become trained around different problems of mental health. These groups apply to people enduring addiction, of bipolar mood disorder, to carers in mental health and to helping peers. The method is elaborated on the base of constant dialogue between professionals coaching and participants. Five educational intentions emerged in this practice: transmission of knowledge, allowing participants to know themselves, arousing the taste to change, liberating speech, use of a universal language. The tool is readjusted progressively because it evolves, at a time, according to the information that the professionals want to transmit and to participants' examples. During the meetings all participants share on an equal base, coaches included. This exchange allows the participants to free their speech, to take confidence in them and to enter a group dynamic helping them to move forward.

Keywords: Group Psychotherapy, Speech-group, Psycho-education, Mutual Aid Associations, Interior Attitudes, Client Centered Psychotherapy, Empowerment

1. Introduction

Therapeutic groups of different types can be organized in order to work with patients with psychic difficulties and in different aims. Their goal is often determined by the practice of a certain activity. For instance one wants participants to acquire a certain number of knowledge and / or of expertise in the management of a definite trouble, to move forward in confidence in themselves, to advance in social cleverness, to become positive instead of discouraging themselves, to recover pleasure, to be in relation with others, to develop useful initiatives for their personal life.

The author wants to concentrate on groups directed by professionals. There is a therapeutic goal: the coach invites participants to work on them, stimulating integration of the data transmitted by the subject of the session, encouraging everyone's speaking up during the session as well as interaction of participants between them. For example, the" speech group" unites people touched by the same problem with an aim to facilitate the expression of participants. In that case, one can unite people enduring addiction, bipolar mood disorder, and family members of individuals affected by a psychic illness or other carers, or merely people who wish to become trained and sharing with others on various problems of mental health.

Coaching such groups, it is important to take care of what the participants expect. For example they want to have some information on psychic illnesses, to learn new notions in order to improve their behaviours, to understand what happens in them when they are in hold with a psychic problem. They look for tools to work on them: to understand their own emotional reactions, to communicate with the patient in the case of family members, to manage stress better. And they want to develop their expertise, to feel better and more confident in the future by a better coping in their present time.

2. Examples of Group Practices in Therapy [16]

The goal is not to present all group therapies; some are mentioned as well known examples having been included in therapeutic programs; it is about French examples. The originality of the author's practice will be shown then.

2.1. Institutional Psychotherapy [1]

This trend was developed from the fifties. Different psychiatrists, for example Paul Sivadon, Georges Daumezon, Lucien Bonafé, Paul-Claude Racamier and Henri Ey had described the pathologies of patients. The institutional answer was sometimes inhuman and, in this case, especially applicable of the time. These psychiatrists proposed, at a time, an effort of theorizing and different therapeutic solutions, in a goal of improvement and structural reform. To this period is born the first tentative to encourage patient's responsibility associating them with their hold in charge and allowing them to benefit from psychotherapy within the institution that welcomed them for a stay. Some psychiatric clinics have been founded proposing institutional psychotherapy: one can mention the examples of Saint Alban (Tosquelles), La Borde (Jean Oury and Gouattari), Saint Martin de Vignogoul (Enjalbert), La Chesnaie (Jeanjirard), The Day Hospital La Velotte (Racamier) and La Chavannerie (Antoine Appeau).

In particular, Paul-Claude Racamier underlined the character alienating the psychiatric institution that reinforces psychotic patients' pathology, if the nurses don't think about their practice. Marie-Noëlle Besançon [3, 4], refers to Racamier in her initial book of another institution, "The Guests to the Feast" insisting that "patients" become " psychiatry citizens". Convinced of the necessity to invite patients to become responsible, Racamier prescribed regular "talking actions". For example, the twelve psychotic patients treated at the day hospital La Velotte live alone in a lodging managing them. During the day, they go to the day hospital having individual and collective therapy.

2.2. The Place of Education in Therapy

There is no limit between so called therapies and those proposing education or rehabilitation. Carl Rogers [8] himself mentioned psycho-educational aspects of Client Centered Therapy initiated by him. For instance, techniques aim exploration of symptoms in tie with different domains of affectivity but also cognitions. All disorders are explored. During therapy, participants will be encouraged to identify their disorders trapping them. They are invited then to take support on their resources in order to develop them, which encourages rehabilitation and recovery.

Different methods of psycho-education proposed to patients or their family members teach precise information on psychic illnesses, medication and how to cope with the illness. It is important that every patient participates in his /her care, understanding and accepting treatment, mentioning side effects occurring, expressing his/her suffering. Professionals construct therapeutic alliance collaborating with the patients and family members.

Cognitive remediation therapy gives itself objectives to act on patients' difficulties focusing on their attention and concentration, dragging memory and verbalization, using their executive powers correctly and keeping their social relations. Patients are encouraged to work on their recovery in order to overcome deficits when occurring.

Some methods are standardized and called "therapeutic education". The "PROFAMILY program ", developed in Canada is proposed in numerous regions in France, Switzerland and Belgium; it brought its proofs. Psycho-education constantly evolves. Since numerous years, Professor Nicolas Franck [6] develops and improves such programs in the domain of schizophrenias. One can underline that these programs aim at improvement of social cognition, of theory of mind (ToMRemed), practice of acknowledging emotions, practice of social cognitions and interactions. But, as Professor Darcourt [5] said: "All psychiatrists can achieve this psycho-education", this shows that it is above all about a therapeutic attitude that expresses itself in the relation with the concerned persons. It is about giving them some explanations according to their expectations: to patients and their family members, listening to them and conversing with them.

2.3. Mutual Aid Associations

Such groups are often called "self-help groups". Besides the organization of regular meetings, these associations propose a support to other people in difficulty. A telephonic contact is usually offered to individuals in crisis, contacts are organized welcoming people in need. Information on the illness is provided by booklets, a library proposes some items to borrow. The concerned persons will be informed on possible and advisable care as well as different places of care.

Helping-peers and helping-peers researchers have now a particular place. Their promotion is made in France by WHO Collaborating Center CCOMS, controlled by Jean-Luc Roelandt; a book is signed by Jean-Luc Roelandt and Berenice Staedel [7]. Helping-peers are a new type of professionals; they are trained in Lille at the CCOMS or at the University of Paris VIII. The future helping-peer must have an appointment in a health-care institution to be able to follow the training. International experience inspires French teaching: "L'association quebecoise de la réadaptation psychociale" (AQRP).

3. Speech Groups: The Author's Experience [9-15]

The author's group practice is directed by professionals: psychiatrist, general practitioner, psychologist, nurse, social worker. Before getting involved in coaching a group, one must elaborate a certain number of subjects in order to answer participants' expectations. Every subject must be

prepared: it is required to have the interior experience of the subject in order to explain the emotional and behavioral context. One must be motivated by coaching a group. Writing a paper with its content is helpful: it will be the support during the sessions. One has then the choice to use the support reading different paragraphs but avoiding giving a lecture: one must invite participants to speak up on a regular basis. They are expecting to be allowed to talk: daring expressing their feelings in front of others in an understanding ambiance, they advance in confidence in them and they enter in a better knowledge of who they are and of their operating manner. A subject must be communicated more than taught. The coach has also the possibility to question participants about their feelings and their experience of a certain problem instead of giving them an explanation.

It is important to use a universal language with comprehensible words by a large public, observing that what is said arouses the participants preexisting experience. In this way they will be invited to speak up mentioning their personal examples. The coach must feel the emotional context when speaking and observe the reactions of the attendants. Sometimes someone silent should be questioned about his/her experience to share: some don't dare speaking up but become able when stimulated. Sometimes it is desirable to question everyone to mention a personal example. The coach must sometimes give his /her personal example: participants appreciate that the coach is located on the same plan than them. Personal experience of individual accompaniment is helpful to coaching a group. Observing oneself in situation of one to one helping relationship creates a new relationship towards oneself: becoming one's own tool accompanying individuals and groups.

Participants also interrogate the coach on precise medical questions: that's where the doctor finds his/her place as coach. One does, in this case, deliver an answer useful to the entire group. At other moments, a synthesis can be made between different holds of speech of the participants to explain common points or divergences. It is important to keep contact with the subject of the session and the message that one wants to transmit. Such questions can call on a more global research: one can be invited to write up another subject or to work again on an existing subject to bring some improvements there. It is important that such a therapeutic group evolves thanks to the involvement of people who use it on the one hand, and to the coaches' observation allowing stimulation and research.

The presence of two coaches is useful, one directing and the other observing and accompanying. The director must be careful to transmit the subject to be integrated by the participants. The accompanist can observe their reactions better and can intervene, for example, if a special person is unwell, observing also if someone would like to speak up but doesn't dare and also intervening if someone doesn't facilitate interactions among others, damaging the emotional climate. To this topic, one must say, at times, that one doesn't speak of people who are not present in the group; each must center oneself on one's emotions and experience. Also participants are not allowed to discuss when someone shares his /her examples or cutting speech of another participant. Only the coach is allowed to cut speech, necessary sometimes when someone talks for too long. It is fundamental to affirm the rules of the group: it is not a group of general discussion, what is said during the session must not be told elsewhere.

3.1. Emergence of Educational Intentions

The author began to initiate a first speech group with the team of his addiction center in 2001, aiming at individuals suffering from various addictions. Client centered therapy determined an approach where predominates at the same time, the aim to transmit some messages to the patients and stimulating their involvement.

Listening to others or giving their examples help participants take a distance to their problems: they hear the teaching of the coaches, ask their questions, speak of their experience, exchange with others. A space opens up which is destined to them: they can speak up or merely listen. The sharing of the experiences acts on their emotions and cognitions, which enables to question them encouraging that they work on themselves. Five educational intentions have emerged from this practice:

1. Transmission of knowledge that concerns useful elements for their progress,
2. Knowledge of themselves as regards personal behaviour and discernment,
3. Wakening of the taste to change by activation of positive resources,
4. Liberation of ability to speak up,
5. Use of a universal language accessible to everybody.

Every participant will be welcomed for what he is, taking into account his/her course. The involvement with others knowing the same problem permits identification seeing oneself in the mirror of another: "I feel less alone ". "The fact to see you moving forward gives me desire to try also ". Some fears must be cleared however: that the problem of the individuals is identified by others; to be seen in one's distress, to feel judged, not to make oneself understood. The fact to speak before everybody constitutes a doorstep to pass; in the beginning, some can only express themselves on individual base. However the experience to take the floor before the other often opens the way to other sharing. Some remain sometimes silent but continuing to come: attentive monitoring also has a profit.

To be able to deposit one's suffering in the group and to discern the fight of the other enables sharing: putting some words on one's emotions has a liberating effect. The group is thus a land of experimentation to evolve toward elaborated reflection permitting constantly a finer analysis of oneself and better management of one's problems.

Participants confirm that the involvement to the group touches them in their emotions. They recognize themselves in what is said by others, they feel included and respected. The clarification of their feelings invites them to accept themselves then to move forward according to new discovered elements. They take confidence in themselves;

their desire to live is touched, which is a lever to continue the daily fight. They become builders of their changing, whereas before, they often thought that they were hit by a fatality that they had to undergo. This monitoring of oneself is previous to be able to listen to others beyond the words but joining the feeling of the other. A new communication develops, and the coaches must underline what is new showing progress: participants learn to react giving their personal examples. They dare to share from their deep feelings, and often, express their empathy towards someone else who is in struggle. Bonds among participants are built up.

Going farther in the domain of self-knowledge, wakening of personal experience is the fertile land on which all knowledge can be rooted and integrated. Participants integrate what they are taught because they confront it with their experience, thus becoming part of themselves and they can apply it to their personal life. If people are seen in one to one helping relationship, they often say that they think about what is said during the group and that the examples have become part of their lives, and that they try to improve their behaviours and their communication with partners or friends.

3.2. Organization of a Speech Group

It is possible to be inspired by the educational intentions and the experience of coaching a group to put different types of group in place in order to join various publics. A certain number of elements must be respected.

The *public must be targeted*: for example the author coaches four groups, for people enduring addictions, for people enduring bipolar mood disorder, for families of patients affected by a psychic illness, and he trains a group of helping peers on voluntary basis. One must only admit the targeted people to a precise group. One doesn't come to a group for people enduring addictions if one doesn't feel concerned by the problem. One cannot participate in a group of bipolar patients if not concerned. If one has a psychic illness, one cannot participate in meetings of a group dedicated to family members and other carers: this rule allows family members to speak of their difficulties outside of the patient's presence.

The *conditions of organization* must be defined. For example the group for people enduring addictions is organized every week, insofar as these patients need to be able to deposit their suffering regularly to receive an answer by professionals. In our practice, the other groups are organized to a monthly frequency. But it could be possible to organize the groups for people enduring bipolar disorder more frequently, every week or every two weeks. The groups for carers could also be organized more frequently distributing teaching modules during three or four months.

The *length of a group session* must be defined. So because of the epidemic of the Covid-19 coronavirus, all groups had been suspended from March 2020. The groups have been taken then in videoconference during winter 2020/2021 and have only been organized from face to face from June 2021 but limiting the sessions to one hour, limiting the number of participants to 10.

The *rules of the group* must be recalled from time to time at the beginning of a session. For example: the cell phones must be turned off. What is said in the group must remain in the space of the group, the examples must not be told in another outside context. One doesn't speak of absent people, meaning that one doesn't speak of others. Each participant must rely on what he/she feels, giving personal examples drawn from everyday live and behaviours. The participants must not discuss with others but listen to a person giving an example until he/she is finished: they are thus encouraged to let themselves be touched in their own experience, and they can request to speak giving a personal reaction to what they heard.

Counter-indications to the involvement to a group must be identified, but they require some nuances. Psychotic patients must be consolidated. Patients suffering from personality disorders can be invited because they also identify themselves to others, helping them to find a distance to their problems. The rules of the group help them to respect others; they learn to manage their frustrations. Phobic patients can participate under the condition to be put in confidence, and they will be told that they can listen; they are not obliged to speak. In their case, individual psychotherapy will be proposed in complement of the group. It may happen that a participant uses the group to exercise an influence on other people in state of weakness: in this case it will sometimes be necessary to exclude him /her in order to protect the others.

The subjects should be constructed according to *logic of modules* permitting a certain progression. The author finalized five general teaching modules: functioning of what is healthy in one's personality; different factors of vulnerability; associated pathologies; somato-psychic phenomena; how to move forward?

Patients learn to *translate their «sufferings» in "words ."* The aim is that they can always make the tie with their life, the chosen subject acts as catalyst. Each participant will be able to take his/her place within the group letting himself/herself becoming impregnated by the content, listening to others and giving his/her experience if he/she wishes it. The term of "the box to tools" is sometimes used: listening, the participants pick examples of behaviours to adopt, they confront them to what they experience, and they continue reflecting on what is important in their daily life.

The *confrontation to the examples* of the participants during the sessions is another element for the coaches to adjust the tool of the group to the needs expressed by the participants. It is as important to receive a participant's remark that says that he/she doesn't understand what is said thus showing a certain degree of maturity, what solicits the intervening party to be clearer in their subjects, and allowing giving a spontaneous example.

A *group method is constructed evolving regularly* in confrontation with the scientific explanations, the texts are put up to date, they are regularly modified and completed and new subjects are elaborated.

The attentive monitoring drives the intervening parties to experiment *interior attitudes* described by Carl Rogers [8]

taking support on the empathetic understanding, the congruence and the unconditional positive attitude. One can underline the necessity to practice patience because moving forward takes time, practicing welcoming each individual and allowing him and her to grow at personal speed. One has to be respectful of personal choices of the participants, and to believe that they are able to discern what is best in their life. These attitudes are liable to stimulate their strengths and their own faith in them.

Beyond the words emerges a *group dynamic*. One can underline four factors: preparation by the intervening parties, participants' involvement, observation of group dynamics, and the resumption and reflection after the session aiming at improving the tool. So the construction of the group won't only be a conceptual work from theoretical data, imposed to participants, but it evolves in interaction with them permitting its improvement.

3.3. Setting up of the Group of Family Members and Carers

At the origin of the group with family members, there was a nurse's observation that had heard in home visits of patients some demands on behalf of the families: "We would like to understand better our son's/daughter's illness. We are troubled because of his/her behaviours, we don't know how to react. We feel all alone with this illness, we would need to exchange with others." Home visits seem facilitating these confidences because the families are in their usual environment, whereas they express less their feeling of vulnerability when they are in the doctor's office. Consultation being granted to the patient, they fade away and a lot of their non formulated questions remain without answer.

Often also, the families don't dare to ask meeting the doctor to tell their observations, their ideas and beliefs. It is necessary to make steps towards them: they are very in worry by the problems put by the illness but do hope for improvement, or even recovery. They blame themselves for not having remarked the illness earlier. They can think when nurses give them some instructions as if they tell them that they are not competent in their manner to act. In this case, they are hypersensitive to all critical speech according to their behaviour: their guilt wakes up, which often entails distrust towards the psychiatrists. They must learn how to deactivate these defensive mechanisms.

The family members feel a desire to help the ill person, in particular parents of a young when the illness begins during adolescence or in the beginning of adult age, or the spouse, to all age, when an illness declares, get settled and evolves. Wanting to help the other that is in need is a deep aspiration of the human being: it constitutes deep bonds in the development and affirmation of the ties between counterparts.

But often, they disregard their own needs and aspirations, being suspended to the fluctuations of the illness, alternating between hope for improvement and discouragement when occurs a new crisis. Prohibiting oneself from taking personal needs and aspirations into account because of guilt has some consequences for their own psychic and physical health.

3.4. Objectives

In the author's experience, coaches of the group of family members can be also psychiatrists in charge and his /her team. The objectives are a little different from a group that targets the involvement of patients. Subjects have been selected according to several needs around *knowledge***:**

1. Different psychic illnesses with their symptoms,
2. New achievements of psychiatric research,
3. Medications with their therapeutic aims and undesirable effects,
4. Caring institutions with their goals,
5. Psychological and psychotherapeutic treatment,
6. The legal context including mental health act,
7. Guardianship for adults,
8. Psychic handicap and rehabilitation.

Another category of needs articulates around the notion *to become more competent* in the management of the illness of a near, with the desire to know how to behave in a situation of crisis, which orientates toward the establishment of a partnership with a nursing team.

A third category of needs concerns the awareness *to be oneself in situation of vulnerability*: the families want to learn managing difficult situations better. Only very progressively they consider their own suffering and that this one is not always linked to the illness of their near.

Since the creation of the group for the families in 2002 a notion is specified regularly in scientific literature and conferences: *empowerment*. This notion concerns the patients as much as the family members themselves. Participants in group therapy send back that they feel that their suffering is taken seriously on the one hand and that they understand better what their son or their daughter undergoes on the other hand but especially as they feel better armed to face the illness.

The group has a *training function of the families* who learn how to identify their emotions and they recover a new expertise in coping with the illness. They move from their initial desire to inform themselves to a new desire to feel good, and they learn to take their personal needs into account. When family members feel good the patient benefits from it.

A *space of speech* has been put in place with two goals: becoming informed and trained. Participants can ask all their questions and receive answers by professionals. There is also identification with other families in distress which creates solidarity between them.

3.5. The Profits of Group Therapy for Family Members

Sharing in the group has a stimulating effect on participants. They learn to *identify their emotional reactions controlling them*. They are encouraged to identify their instinctive reactions because these could have a negative effect on the ill person: this one could receive them like intruder and persecute himself/herself.

There is an *active reciprocity*: psychiatrist and nursing team benefit from the information on patients' behaviours, if the case arises. The families on their side need to hear the observations of the nursing, their preoccupations, their

worries, their points of vigilance and their requirements towards patients. In such a group is practiced an exchange on equal terms: relation facilitating the establishment of partnership.

The *patients themselves benefit* from the involvement of their family members to the group, insofar as these become more relaxed and more skillful in communication. When the level of anxiety decreases, life becomes easier, which reduces stress in everyday life; this is a factor of stabilization.

Participants learn to *express their desires*. They ask to meet the team members more easily, and they allow themselves some vacancy in order to fulfill their resource which gives them strength. Sometimes they move from their home leaving their son or daughter alone, which they didn't dare before.

They also learn to take a distance to the illness identifying good and bad aspects. The illness exercises a pressure, certainly, but it is always important *to rely upon a personal resource*, which permits moving forward. In each person there is a capacity of resilience and so one can learn to take support there. It is important to recover strength by the best of oneself, using all one's expertise. One discovers how to take a rest in oneself, which arouses feelings of joy, happiness and freedom.

So it is important to *deliver oneself from doom* as fate that hits or punishes. Because each individual must preserve his/her own strengths, being careful not to reach one's limits, avoiding accumulation of negative energies so called negative stress.

4. Conclusions

The author finalized a method of speech group with several essential elements. Five educational intentions emerged of the practice: the transmission of knowledge, to allow the participants to know themselves, to wake the taste to change, to free the speech, the use of a universal language. This method can be adapted to different types of patients: individuals enduring addictions, patients suffering from mood disorders, family members of patients. The tool is readjusted progressively because it evolves, at a time, according to the information that the professionals want to transmit and of participants' examples. During the meetings all participants share on an equal base, coaches included. This exchange allows the participants to free their speech, to take confidence in them and to enter a group dynamic helping them to move forward.

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Biography

Thomas Wallenhorst. M.D., Psychiatrist, Psychotherapist, Addiction Specialist. The author was born in Germany; he qualified as medical practitioner and got his M.D. degree. He then moved to France where he qualified as psychiatrist and psychotherapist and later addiction specialist. Working all the time in the Adult Psychiatrie and Addiction Treatment of Semur en Auxois, he opened a Day-Hospital for adults, an Out-Patient Unit for treatment of addiction and a Day-Hospital for addicted patients. He developed a specific group therapy in a patient centred approach.