

Final Integrative Paper

Sairam Babu

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Introduction

Group therapy is a dynamic therapeutic medium that can be effective in the treatment of a variety of mental health conditions that allows participants from various contexts and backgrounds to join with a common goal. Each group is unique in its make-up and general therapeutic atmosphere. Therefore, the group leader has the latitude to introduce a variety of different concepts, interventions, and approaches in order to best help the group reach its desired goals.

Background of my group experience

My experience with group therapy took place at a homeless drop-in center in Queens, NY. A drop-in center is a social services hub that can provide immediate emergency shelter for single adults. While many clients seek shelter as they please, they can stay for a longer period to eventually transition to a longer-term housing development. As I did intakes and psychosocial assessments on many incoming clients, it occurred to me that many clients expressed some sort of mental health concern. For the clients who did not have an expressed mental health concern, they consistently demonstrated several self-destructive emotional or cognitive patterns.

After some needs-based assessment interviews with the clients and collaboration with the clinicians within the organization, it was determined that a treatment group would be the most effective way to help the clients meet their goals. Due to the nature of the drop-in center and client demographic, there were some logistical and cultural factors that needed to be considered. Firstly, most of the clients had not received any form of mental health treatment aside from medication management. Many of the clients in the group had been experiencing homelessness for quite some time along with a variety of other historical traumas. As a result, many had

learned behaviors that suppressed the healthy expression of feelings and instead expressed “toughness.” Additionally, the group was entirely made up of members of various minority groups, many of whom often viewed mental health as taboo. Therefore, the interventions would need to be highly practical to be better received and culturally compatible.

Theoretical Foundation

While there are plenty of groups that operate from a variety of perspectives, frameworks and approaches, my approach is heavily rooted in cognitive theory. Developed by Dr. Aaron Beck, cognitive theory emphasizes the connection between a client’s thoughts, beliefs, and actions to their mental health symptoms. In *Cognitive therapy and the emotional disorders*, Beck argues that mental health symptoms “are not necessarily the product of mysterious, impenetrable forces but may result from commonplace processes such as faulty learning, making incorrect inferences on the basis of inadequate or incorrect information, and not distinguishing adequately between imagination and reality” (Beck, 1976/1991, p.19). Cognitive theory works from the theoretical assumption that “the affective response is determined by the cognitive way an individual structures his experience” (Beck, 1963). This “structure” is the way a client interprets the world around them, usually derived from a dysfunctional view of themselves, others, or the world. When a client’s interpretation of a situation holds several cognitive distortions, it is often associated with dysfunctional core beliefs. The aim of cognitive behavioral approaches is to work with the client to identify their own dysfunctional core belief by questioning their own thoughts. Many psychological problems stem from misconceptions and cognitive distortions and they “can be mastered by sharpening discrimination, correcting misconceptions and learning more adaptive attitudes” (Beck, 1976/1991, p.20). The end goal is to use rational thought to help the client clarify feelings and learn how to treat their own mental health symptoms.

Treatment Approaches

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is the therapeutic modality employed by Dr. Beck stemming from his own theoretical approach. CBT is a form of therapy that focuses on “a time-limited, active, directive, transparent, collaborative, present-focused, didactic, evidence-based approach that relies on empirical validation of its concepts and techniques” (Corey, 2015). CBT assumes that many dysfunctional behaviors or beliefs derive can be changed by the learning of new skills. An additional assumption that CBT operates from is that presenting concern expressed by the client is the problem, as opposed to a symptom of the problem. While CBT may lack the depth of psychoanalysis, it is readily implemented because it does not require a prolonged probing period.

Key Features

One of the key features of CBT is its reliance on the scientific method and data collection in order to provide effective treatment. CBT emphasizes the use of behavioral assessments that are backed by research to establish a baseline for where the client is prior to the use of any interventions. Through a collaborative discussion with the client, specifically defined treatment goals are developed with specific metrics of success. Based on the treatment goals, specific interventions are utilized to help the client meet their goals. Finally, towards the end of the agreed period of treatment, another assessment is done to see the effect the intervention has had on the client.

Role of Group Leader

The group leader of a CBT group must oscillate between several different roles in order to best help the group along. The leader must function more as a teacher during the early stages of the group. This is primarily because the group is still within its initial stage of development where the group members are apprehensive about the group and lack the knowledge that comes through psychoeducation. However, as the group progresses into the treatment stages of the group, the leader must adapt the role of facilitator to help clarify goals and encourage the group to apply the chosen interventions correctly and consistently.

Applicability

CBT is widely used across a multitude of demographics and settings due to its ability to be employed quickly. CBT's time-limited approach was also ideal when considering the therapeutic approach because the clients who participated in the group were present in the drop-in center only for a short period of time. Therefore it was paramount to provide clients with the tools and knowledge they needed in order to change some of their maladaptive behaviors or dysfunctional beliefs.

Gestalt Therapy

While a large part of my framework comes from the cognitive behavioral approach, there are concepts from other treatment approaches that I heavily incorporate into my approach to treatment. In *Gestalt Therapy Integrated: Contours of Theory and Practice*, Polster outlines his approach to therapy as helping the client to maximize their own self-awareness by taking personal responsibility of their choices. While it is important to recognize that choices are not made in a vacuum, it is equally important for clients to take responsibility for their feelings and choices. Personal responsibility for choices and feelings is a requirement in therapy, especially

from the cognitive behavioral approach, because when the client assumes responsibility of their feelings and behaviors, they are then able to change them. Additionally, there is a time and place where confronting client's feelings can be beneficial, especially when a client is consistently displaying resistance. However, it can only be done if the therapist has built an environment where conflict is not viewed as a fight, but rather coming from a place of good will.

Rational Emotive Behavioral Therapy

Another large contributor in my theoretical approach is Rational Emotive Behavioral Therapy (REBT). Founded by Dr. Albert Ellis in the 1950's, the REBT model asserts that when negative events occur, people will develop irrational beliefs about the situation that are absolutes. For example, someone might think everyone must like me or else I am worthless. These absolute thoughts, while dysfunctional, are also tightly held and require a variety of different interventions in order to correct them. REBT does not necessarily make the client more resilient to negative emotions, but rather teaches the client to experience negative emotions in a healthy way without allowing those emotions to create new, self-destructive beliefs.

Key Features

Where REBT plays into my practice approach is through the A-B-C theory, which is one of its key features. The A-B-C theory breaks down the cognitive processes and makes it more accessible to people who may have no experience with more introspective concepts. REBT asserts that after an Activating event, the client has a Belief about said event. This belief can often be irrational. The Belief then triggers an emotional Consequence.

While, REBT also emphasizes taking responsibility for beliefs and consequences, it equally emphasizes that the client has the ability to change their beliefs and resolve their

disturbance. To resolve mental health symptoms, REBT teaches clients to Dispute the dysfunctional belief through scientific methods like Socratic questioning. This cognitive restructuring leads to a new belief, or Effect.

Role of Leader

REBT assumes that people's irrational beliefs are so deeply ingrained that they will not change easily, so leaders employ a variety of "active cognitive and emotive techniques to bring about cognitive change" (Ellis, 1996, 2001b; Ellis & Dryden, 2007). REBT group practitioners favor interventions such as questioning, confronting, negotiating homework assignments, and helping members experiment with new ways of thinking, feeling, and doing. REBT group leaders are active in teaching the theoretical model, proposing methods of coping, and teaching members strategies for testing hypotheses and solutions.

Applicability

REBT shapes my theoretical framework by encouraging personal responsibility. Similar to how Gestalt therapy influences my framework, REBT emphasizes the client's responsibility of their behavior and feelings so as to empower them to actively change. Many of the clients in the drop-in center have been marginalized on multiple levels for most of their lives. They have many instances of being treated unjustly by people and society. As a result, many clients focus on external factors for how they feel or act. While not discounting or discrediting their history, REBT informs the client that their reaction to the event is the source of their symptoms, not the event itself. Therefore, since their reaction is their own, they can change how they react to certain events. This empowers the client to move from simply being victims to living more self-determined lives.

Solution Focused Behavioral Therapy

Solution Focused Behavioral Therapy (SFBT) is a therapeutic method that is, like other cognitive therapies, goal focused and time limited. However, it differs in that CBT and REBT are focused on the past and present. SFBT is focused on the client's future and their future goals. Originally developed in the 1970's by Steve de Shazer and Insoo Kim Berg, the goal of SFBT is to help members shift from talking about problems to talking about solutions to those problems. The therapist works to assist members to recognize their own competencies, strengths, and resources that will lead to the goal chosen by the client.

Key Features

One of the hallmark traits of SFBT is the "Miracle Question." The "Miracle Question" is an intervention technique where the practitioner asks the client how their life would look if their problem was miraculously resolved overnight. This question is used as a base in order to collaborate with the client to come up with solutions. The "Miracle Question" is foundational to SFBT because SFBT is a future-focused form of therapy. Where most other forms of therapy look to the past, SFBT looks to the future. Deshazer even argues that the cause of the problem, the problem, and the solution are not necessarily linked together (Corey, 2015). The problem is still the problem regardless of the cause and that solutions are still solutions, regardless of the problem. In this, SFBT emphasizes that the client be optimistic in their endeavor to solve their problem as well as focused on their strengths as opposed to their deficits.

Role of Leader

The leader in SFBT is there to facilitate and collaborate with the client. In a group setting, the client is the expert, who can diagnose the problem and develop solutions, as opposed to replying on the leader to provide the appropriate interventions. The leader is meant to defer questions back to the client or to the group to establish a more collaborative environment. The reason is that since every client is unique, so too are their solutions.

Applicability

SFBT's solution-focused approach comes into play with my approach to group therapy when clients seem to be fixated on external problems that are outside of their control. Clients in the drop-in center have experienced quite a bit of relational and institutional maltreatment. Almost all of the time, they have no control over how they were treated. However, many clients can get stuck in the mindset that the only way they can improve is that if "those people" or "the system" were to change. Lofty as that idea may be, it is unrealistic and probably based more on resentment than on principle. By shifting the focus from problems to solution and incorporating SFBT's positive psychology, I collaborate with the client(s) to redefine themselves by their strengths and not their weaknesses.

What did you learn about group process from participating in this group?

Participating in a group composed of my classmates was an interesting experience. The group dynamic was interesting because I had been in class with a few of the group members so there were pre-existing relationships in place as we began the first session. On the other hand, there were group members who I had never met until the first time our group met. My initial hypothesis was that we would instantly come together and start the group at Stage 4 or the Working Stage. However, we still started in Stage 2 or the Initial Stage. I realized that despite the group members' previous relationships, new groups still need time to explore the group structure

and expectations. While the Initial Stage may not have taken as long as a group of relative strangers, it was necessary for us to move forward.

Group personality

The overall personality of the group changed over the course of the semester as we familiarized ourselves with one another and the assignment. Initially the group was reticent to brainstorming ideas for how to complete the task assigned to the group. However, as time went on and no one indicated that they were seeking a leadership role, two members began to take on a directive role in the group where they shared their ideas of how to complete the assignment and assigning varying roles and responsibilities to other members. By the third group session, the two leaders were still effectively moving the group along but other members began to participate more as well.

What makes groups work effectively?

Group therapy is an interesting treatment modality because it can have excellent planning and excellent group members, but if the leader is unable to effectively guide the conversation, then the therapeutic effect is nullified. During the group, there would be frequent outbursts from disruptive group members during various times that completely derailed the group. For example, during one session where we were discussing a recent rise in school violence and bullying, a group member joined the discussion late. When he joined the group, it became apparent that he had an external conflict with another group member. They both became agitated and required the leader to take a firm stance to get them to calm down. While the group leader did her best to return the group to normal, it made the rest of the session hard to focus. It's interesting how something disruptive like a latecomer, a conflict or even an argument can lead to such detrimental effects of the environment. I think conflicts are a natural part of being in a group and should not be

ignored. However, the leader needs to take control of the situation quickly so that even the conflict can lead to growth for everyone.

Stages of Group Development.

Stage 2 – Initial Stage

As our groups were pre-assigned, we were able to skip Stage 1 (Pregroup Issues) and go directly to Stage 2 which is the Initial Stage. The Initial Stage occurs in the early stages of the group where group members are still getting acquainted with each other and the leader. Our group displayed a mix of characteristics when in this stage. There was a lot of uncertainty in the way we spoke and conducted ourselves. Group members were slow to speak and sought out affirmation whenever suggestions were made or feelings were expressed. This was primarily attributed to the group still establishing social norms within itself. Additionally, there was not a lot of risk-taking in terms of feedback given from group members. It was entirely empathetic listening and affirmation of the person's feelings. This, as well as intentionally developing rules, was effective in building trust among group members and the leader.

Stage 2 – Transition Stage

The Transition Stage was where the group deviated from the expected characteristics in development. In the Transition Stage, it is expected that there might be some conflict that arises between members and some power struggles with the group leader. However, our group was largely devoid of conflict, with one planned exception. When ideas were offered, alternative ideas were also freely offered with minimal to no pushback from anyone. I attribute this entirely to the fact that some of us had pre-existing relationships and that we are all training to be social workers and adept at avoiding non-constructive conflict.

Stage 4 – Working Stage

I think our group transitioned from the Initial Stage to the Working Stage quickly, which in turn transitioned our group to more of a task group. After the first two weeks in the group, we became more task oriented in our discussion. In the beginning stages, whoever was the leader that week would typically start the discussion with a welcome and spend time to establish the group rules. However, by the third or fourth session, we would skip the rules and go straight to what we were meeting to discuss. While it did diffuse the therapeutic environment, it did focus the group discussion on the here and now as opposed to focusing on establishing appropriate behavior and being unsure of whether or not we are accepted by the rest of the group.

Conclusion

The group therapy setting was a form of therapy that I was inexperienced with and something that I discounted as not very effective. However, that is certainly an opinion born from ignorance that actual experience. In reality, group therapy is a form of treatment that can allow clients to receive support from the community instead of just the leader. In regards to the homeless community, many have experienced a multitude of traumas including the lack of a supportive environment to deal with their traumas in a healthy way. By taking a blended model of CBT, REBT and SFBT, the cognitive model can be made more accessible for people who have spent a bulk of their lives on the fringes of society. Regardless of the setting and group demographic, there is a significant level of planning and purpose that goes into creating an effective group. However, when done with care and thoughtfulness, it can provide the support for the clients by empowering them to have control over their mental health.

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