There are Therapy Groups and then there are… groups

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What makes a group transformative and exciting – from the perspective of those with lived experience? What renders a group effective and seen to deliver measurable, evidence-based outcomes – from the perspective of the clinician? Why are these often so different?

Older consumers may have experienced many different types of group over the years; I've been in encounter groups where all is bared and emotion is viscerally felt so that catharsis may be achieved. I've taken part in groups informed by *Transactional Analysis* and others by *Gestalt Theory*. Then there are *psycho-educational* groups that seek to inform and put structure around experience and assist with coping (there're a bit of a favourite with carers). A more recent 'flavour of the month' are *Cognitive Behavioural* and *Mindfulness* therapies, e.g. Acceptance and Commitment Therapy, even a blend of these, called MiCBT. *Dialectical Behavioural Therapy* groups are designed for those with trauma-related conditions and programs based on psychoanalytic principles continue to be offered. This is not meant to be a comprehensive list but, it demonstrates the multiplicity of groups and the different types of 'experts' delivering them, many of whom disagree with others! And who knows what else an adventurous PhD student or guru-in-the-making will dream up...

How can consumers navigate the group-work marketplace and determine what might suit them best? Even risking being accused of cynicism, there's always the quick decision based on the quality of tissues, the noisiness or effectiveness of the air conditioning, the size (and even presence) of windows in the room, whether the receptionist smiles at you and means it, or whether the therapist meets with you before, discusses your needs and suggests the best group for you, without '*spruiking*' his or her own program based on generating profit; Twelve-Step groups (e.g. AA, NA, Grow) usually have the best tea-breaks, perhaps because they're peer-run... Underlying these idiosyncratic suggestions is the idea that a therapist, who cares for the therapeutic environment, will also care for consumers.

Groups have a particular magic that is less about the processes and the theories that underpin them and more about the relationship between participants and between participants and therapist. Consumers usually treat each other with dignity, humour, curiosity and empathy. There is wisdom in shared experience and mutual journeying towards a better place; the tone for such experiences is often set by the facilitator, particularly in the early stages of the group. Respectful relationships, sensitive to transactions of power, establish fertile ground for change to occur.

Rather than making an impersonal but comprehensive list of things to think about, I'd like to tell you what has worked for me and what I wish I'd known earlier in my journey, adding - of course - the inevitable comments and suggestions (sorry, I couldn't help myself!).

Selecting a group

While the word 'consumer' suggests the ability to shop around, compare programs and exercise informed choice, like most things in mental health, these are illusory; usually we are referred to a provider by a GP or psychiatrist, particularly when the referral forms part of a Mental Health Plan, in which Medicare pays (most of) the costs, even though the therapist is 'private'.[53] Different professions often have a list of members working locally, their areas of expertise, the theories they employ and whether they run groups or one-on-one therapy only. I've found that the information provided is usually very cursory and certainly not comprehensive and not really conducive to informed choice.

Reflecting on a group I was referred to recently; I was so grateful to be accepted that I didn't do due diligence for myself. This turned out to be a psycho-educational group, run according to eclectic 'pick 'n mix' principles (a bit of this and a bit of that or '*50 ways to leave your lover, become more successful, lose weight and become empowered*!'). Some suggestions conflicted with others and this led to a frustrating and confusing experience. The facilitator ran the group using a chalk and talk method (mostly one way), reminding me of lessons at school where the teachers taught and we listened (sort of...). No power points or interactive white boards, with the ability to print-off notes, were used. To me, it lacked coherence; keeping track of what was being said was difficult and at first I took notes but later asked for handouts although getting quality handouts took some negotiating.

Although I met the facilitator before starting the group, I didn't know what questions to ask and nor which program could work best for me. Some of the questions I wish I'd asked:

- How experienced are you?
- What qualifications do you have?
- Have you undertaken specific training in group work?
- Which theories do you work from?
- Do you have specific training in this theoretical position?
- Is the group closed or open? (a *closed* group has a set number of participants, who often attend for a specific period of time and no new members can join after the first group; an *open* group means that people can drop in and out and there may not be an end date).
- Where will the group be held and can I check out the room?
- If the group is being held in a hospital, will both in-patients and day patients attend and how does that affect people's experience?[54]

The therapist eventually recommended a different group, with a different therapist and the fit for me was brilliant; unfortunately, he moved on during the program leaving us suddenly high and dry, with lots of unfinished business. For me, the greatest sadness was that I didn't get to say goodbye to the other participants, whom I continue to think about.

Measuring success

Commonly participants are given a short standardised questionnaire before commencing the group, often measuring anxiety and depression. The psychologist running one group I was in asked me to fill out such a questionnaire in the interview before starting the group. When the scores were added up I was told I was depressed and anxious (duh???). She didn't tell me why I was asked to complete it (I assumed incorrectly that it was part of determining my eligibility for the group). I didn't ask about the uses to which it may be put (e.g. research, feedback to government or insurers about the effectiveness of the treatment), where the data would be stored, or who might see it. Interestingly, I wasn't asked to complete the same questionnaire on exiting the program.

Using the '*retrospectoscope*', I suspect that the intention was to determine the success of the group through an (hopeful) improvement in the pre- and post-group scores. If this was so, it would provide a blunt measure indeed; ignoring all other things going on in one's life that may influence us, in our recoveries, as well as the effectiveness of any medication or lifestyle changes, such as suddenly winning the lotto or being able to eat properly. It is also a top-down way of assessing suitability for a program, or its effectiveness and completely ignores any co-construction, between therapist and consumer, about what worked and what didn't. It was just another thing done to us, rather than with or alongside us.

Consumers end up being seen as responsible for failures of the group, such as staff not being respected. Responsibility for the shortcomings of the group may be deflected from the therapist, by blaming participants; similarly, any lack of expertise of staff or poor communication skills, their respect-deficit or indifferent sense of humour may be blamed on participants who are then perceived to be not committed, non-compliant or not working hard enough.

Use of students

Users, of all sorts of mental health services, will be familiar with the presence of students. I've been in this position too and find it galling, not to be asked to give informed consent for the presence of students (asking members of a group if it's OK for the student to sit in when s-he is already there is unlikely to elicit any 'no' responses). I also find it confronting when the student sits alongside the therapist, as if to say, '*Look here, I've already aligned myself with the power in this room*'; students who '*corporate-dress*' lack sensitivity towards consumers who may be unable to afford decent clothes, flash hair-cuts and gold jewellery.

Sometimes students are asked to run a group as part of their learning and assessment; these sessions can be well conducted, or not, or somewhere in the middle. I would argue that participants should not have to pay to attend a session run by a student, that Medicare should not be billed for this and that private health insurers should not be billed either. Universities do not pay therapists for supervising and training students and neither should we or insurers.

Ever had the misfortune of a student, whom you had once known or lectured when they were much younger, practicing 'on you'? I didn't think I would mind until it happened to me and it completely threw me off my already faulty balance. Power now rested with the student, who got to read my file and talk to the

psychologist about me and could go into rooms that were now denied me, because I was just a patient. We didn't even use the same toilet!

In some teaching hospitals or psych units, where students are being trained in particular skills or theories, the one-way mirror may be employed. This involves the group taking place in a room, where one wall has what appears to be a mirror and people on the other side of the mirror, in an adjoining room (e.g. teachers, senior clinicians who are often known as the 'reflecting team'), can observe the group and provide feedback to the student. The student sometimes wears a hearing device and the reflecting team can speak into a microphone to tell the student to try something different, which can result in a very disjointed experience for consumers. It is also ethically questionable because consumers are objectified and are prized for their 'use-value'. Very, very careful informed consent needs to be negotiated; if you are feeling at all fragile and suspicious, don't give permission.

Who pays?

While some group work programs are conducted by government-funded mental health services and at no cost to participants, others are billed to Medicare and/or health insurers. Consumers may be asked to make a gap payment, which raises a number of issues:

- How might these various sources of payment for groups change the relationship between the consumer and provider?
- If a consumer pays for all or part of the program does this change the contractual relationship between service provider and consumer? Does the consumer become an employer of the therapist and how might this change the dynamic in the relationship? Does this entitle the consumer to be more discerning about what constitutes a quality service?
- How do Medicare or private health insurers ensure that the service meets their expectations of care? How might consumers be actively involved in assessing and reporting on quality service?
- If the group is being paid for by a private health insurer, all sorts of hidden costs may be involved. There are a multiplicity of different covers, some have co-contributions, others have excesses; the amount each cover pays for the same service can vary. Sometimes there are limits on the number of services provided in any one year. I've found that receptionists don't understand the complexities of this and if you ring the health fund, you may find that, unless you ask very specific questions, you may not get all the answers you need. My recommendation is to keep asking questions; keep ringing the health fund – a different person may give you a different answer (isn't that usually the case with Centrelink!). Here's a hint: make sure you ask what happens when the group isn't on one week because of a public holiday, because you may have to pay an additional excess yourself, as the individual services occurred more than one week apart. The Private Health Insurance Ombudsman has a useful website with Quarterly Bulletins documenting the number of complaints they received about which insurers, with a number of Fact Sheets and lots more information. You can contact them at http://www.phio.gov.au/

Involuntary groups

These are the groups you don't have an option about attending unless you want to be labelled non-compliant and difficult. They can occur in quite different venues.

Treatment Plans in Private Hospitals- *noun:*
I feel over-programmed already. There should be a programs limitation statute.

MadQuarry Dictionary 2014:26

Patients in private hospitals often report feeling 'grouped-out of their brain' on the program carousel (9am – 10am Ward Meeting; 10am -10.30am Morning tea; 10.30am therapy group; LUNCH; 1pm Relaxation; 2pm- 4pm Art and craft). Private hospitals are compelled by the Funds to offer a program, in order to provide evidence that patients are doing more than sitting around having coffee and watching TV while waiting for an appointment with their psychiatrist and waiting even longer for the drugs to kick in.

In public hospitals, consumers often report their suspicion that groups are used for crowd control; hopefully, female patients will civilise the males (an argument used to establish co-ed schools); better behaved patients will tell the naughty ones to 'put a sock' in it. Groups, of course, give staff a chance for a coffee break, time for a ciggie... Ooops... I mean, catch up on their notes. Many consumers report that groups happen because that's what the program says, not that they may be useful or facilitate recovery. Because many patients, in public psychiatric units, are '*here one day and gone the next*' (FiFo – *fly in, fly out patients*), the therapeutic wisdom underpinning groups in acute care units is questionable, except, of course, for their crowd controlling properties. How can group therapy make sense when consumers are highly medicated? What chance is there of relaxation groups actually working, in the midst of a highly charged, scary and noisy environment! Seriously, public facilities are usually under-resourced, dislocated, patched together, having to cope with staff on shift work and various sorts of leave.

An interesting recent development is that private health insurers are being billed for some involuntary patients, who have private health insurance, who have been admitted to public hospitals.. Who then calls the shots about accountability? Will the same demands that insurers place on private hospitals, to run extensive therapy programmes, extend to public hospitals? What standards will be expected? Who will accredit the facility?

Therapy Participation Dichotomy- *noun*
The irony that public hospital in-patients are largely deprived of appropriate group therapy sessions, while private hospital patients are forced to attend groups 5 days a week, whether they want to or not!

The MadQuarry Dictionary, 2014:26

Conclusions

Like so many psychiatric interventions, psychotherapeutic groups are too often constructed as hurdles to be jumped or endeavours to fail. Regardless of the particularity of the method, the very fact that the psychotherapist is not a group member sets up a potential for status conflict. Although some consumers accept this as part of the deal and are able to work within boundaries not of their making and structures not under their control, others cannot. This is not a personal flaw.

My own experience of DBT (Dialectical Behaviour Therapy) informs my question: after attempting to organise a consciousness-raising group to discuss the causative role of sexual violence and distributing fliers (around the group) that proudly defamed Charcot, Breuer and Freud et al., I was told, "we are not political here..." My actions were deemed 'therapy interfering behaviours' which, at least, seemed to lead to a comprehensive and personalised discharge plan ... (Emerson 2006:3)

The problems of flawed process are often seen as failures of individual people, regardless of how carefully this is expressed. People are seen to lack commitment. Power, when theorised, can be seen as a tool rather than a problem. These issues escalate when people are forced to participate in groups they did not choose and do not want or when people are required to sign contractual agreements in order to participate. Therapeutic groups can work for consumers when relationships are fostered which enable all (including facilitators) to question, change, laugh, support and challenge each other.

Endnotes

53. Federal Government: Better Access to Mental Health - Information about Medicare rebates available to patients for selected mental health services provided by GPs, psychiatrists, psychologists and eligible social workers and occupational therapists.http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat

54. A couple of years ago I attended a group in a private hospital as a day patient. Group members were both in-patients and day patients. I found this really frustrating because participants were in various stages of recovery, it wasn't possible to predict who would be there from week to week and, most frustratingly, people kept going in and out of the group for appointments with their psychiatrist! The morning tea, however, was very nice until the budget ran dry!