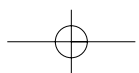
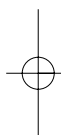
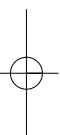


# PART I

## BASICS AND BACKGROUND

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## 1

## Groupwork and Solution-Focused Brief Therapy

'I will show you Hell', the Lord said to the rabbi, whom he took to a large room full of miserable looking people. They all sat around an appetising cauldron of food, but none could eat. The only spoons in the room had long handles, which were long enough to reach the cauldron and scoop up some food, but too long to get the food into one's mouth. As a result, all were frustrated and starving.

'I will now show you Heaven', the Lord said and took the rabbi to another room. This room was identical, with a large group of people sitting around the same cauldron with the same long spoons. But they looked content, satisfied and definitely well-fed.

'What's the difference?' asked the puzzled rabbi.

'Ahh', replied the Lord, 'The group in the second room have mastered an important skill. They have learnt how to feed one another.'

The above Hasidic story was used by Irvin Yalom and Katy Weers to open their first group for cancer patients in 1973 (Yalom, 1995). It illustrates how group cultures can differ and the powerful influence of others in people's lives for good and sometimes for bad. The therapeutic group aims to create a group culture that is positively influential, so that members can literally learn 'how to feed' one another. In particular, solution-focused groupwork aims to establish collective and mutually beneficial goals and to harness the group's resources and strengths towards empowering members to make realistic steps towards these goals in the short-term. Before describing the principles of the approach in Chapter 2, this chapter outlines the development of solution-focused groupwork, in particular:

- 1 Tracing the emergence of solution-focused groupwork from traditional longer-term forms of groupwork, in particular looking at the influence of the self-help movement and a growing cultural preference for strengths-based, shorter forms of treatment.
- 2 Describing the therapeutic factors which give groupwork its unique power for change, and how these are activated in a solution-focused approach.
- 3 Evaluating the research evidence for the effectiveness of groupwork in general and of solution-focused groupwork in particular.

#### 4 SOLUTION-FOCUSED GROUPWORK

### **The development of solution-focused groupwork**

People have always come together in groups to create and achieve things that they could not possibly have done alone, whether this has been to plan or carry out tasks, to teach or learn, or to dialogue about and resolve disagreements. In ancient Irish history there is reference to the mythological 'fifth province' where the kings of all the other provinces would meet to receive counsel and resolve disputes (Colgan McCarthy and O'Reilly byrne, 1995). This could be conceived as one of the first mediation groups!

It is not surprising, therefore, that psychotherapists, though initially only working with individuals, began to see the need to work with people in groups in order to harness the power of group dynamics. Joseph Hersey Pratt is attributed with organising the first therapeutic groups in 1905 when he brought together groups of tuberculosis patients to monitor their progress and to educate them about the disease and its management (Gladding, 1991; Tudor, 1999). Initially, Pratt conceived of the group as a cost-effective endeavour, as it saved time to educate patients in groups, but he quickly witnessed how much support and encouragement the patients provided to one another. To Pratt's credit he recognised and promoted this positive group influence and thus was one of the first theorists to utilise the therapeutic power of groupwork (Gladding, 1991).

Though psychoanalysis in the 1920s and 1930s primarily concerned itself with intrapsychic conflict and thus individual work with patients, there were some exceptions, notably Adler who used group counselling in prison and child guidance settings (Gazda, 1989). During this time, a major contribution to the development of groupwork was to come from Moreno who used psychodrama with adults and children and who first coined the terms group psychotherapy and group therapy (Gladding, 1991). The 1940s and 1950s are often seen as the beginning of the modern groupwork period. Bion (1961), working at the Tavistock in London, developed a psychodynamic understanding of group process and Kurt Lewin (1951) developed 'field theory', giving insight into group dynamics and how people relate to one another in a group context. Lewin's work was influential in the development of training or T-Groups and the subsequent encounter group movement.

The 1960s were the heyday of group therapy and groupwork and led the *New York Times* to declare that 1968 was the 'year of the group' (Gladding, 1991). There was a rapid growth in the participation in groupwork both by traditional clients and by the general public who attended personal growth groups and encounter groups. The variety and types of groups available also expanded and it was a period of great theoretical diversity. Many of the major humanistic practitioners applied and developed their ideas to group settings. Perls (1967) and Berne (1966) applied gestalt theory and transactional analysis, respectively, to group therapy. Carl Rogers applied his person-centred approach to groupwork and he was instrumental in the development of the encounter group movement,

which became a major social phenomenon in America and the rest of the world (Rogers, 1970). Ordinary people, driven by a desire for personal growth and connection with other people, attended encounter groups in large numbers. The 1970s represented a period of consolidation in the development of groupwork. Though participation continued to grow, there was also widespread criticism and an awareness of the potentially damaging effect of groups (Gladding, 1991). Yalom made a major contribution in 1970 with the publication of *The Theory and Practice of Group Psychotherapy*, which provided a research-based and pan-theoretical account of the therapeutic factors inherent in all forms of groupwork (Yalom, 1970).

### *Influence of brief therapy*

Up until the 1980s therapeutic groupwork was generally characterised by a long-term, open-content, open-ended format. Like its parallel, individual psychotherapy, courses of treatment were thought to take several months or even years to complete. However, many research studies during this period found that, even in planned long-term treatments, therapy does not last for an extended time period. In a study of patients referred to open-ended, long-term groups, Stone and Rutan (1983) found that only 8 per cent attended a group for as long as one year. These findings are paralleled in individual therapy where the majority of studies over recent decades have indicated that on average treatments last between four and eight sessions (Garfield and Bergin, 1994). This can lead us to the tentative conclusion that in everyday practice most psychotherapy and counselling, whatever the orientation, is brief.

While traditional groupwork might have been ‘inadvertently’ brief in many instances, there has been a growing interest in planned brief therapy since the 1980s (Hoyt, 1995; Yalom, 1995). As O’Connell (1998: 6) put it: ‘Brief therapy does not mean “less of the same” but therapy with its own structure and process that differs from long term.’ Many writers have attempted to characterise the features of these new brief group interventions (Budman and Gurman, 1988; Klein, 1993; MacKenzie, 1994), which are summarised in Box 1.1.

#### **Box 1.1 Characteristics of brief groupwork**

- Clear, specific goals, which can be achieved in the time available.
- The establishing of good group cohesion as soon as possible.
- A focus on present issues and recent problems.
- Client homogeneity: they have similar problems, goals or life experiences.
- Focus on interpersonal rather than intrapersonal concerns.
- The therapist is active, positive and openly influential.

## 6 SOLUTION-FOCUSED GROUPWORK

The increasing popularity of brief groupwork represents a number of paradigm shifts that have taken place in society. There is increasingly a call for therapy to be cost-effective and accountable and for agencies to address the needs of a population of potential service users rather than a small number of clients who avail themselves of long-term therapy. In addition there is a growing customer preference for shorter forms of intervention (O'Connell, 1998). It is now generally recognised that most clients come to therapy believing that their problems will take only a few sessions to resolve (Koss and Shiang, 1994) and there is some evidence that clients will opt for shorter treatment even when they could pursue extra sessions at no cost to themselves (Hoyt, 1995). The emergence of brief groupwork represents a response to the new context in which therapists and clients find themselves. Currently, within mental health services in the UK and the USA the majority of groups offered to clients are short-term, issue-focused groups such as 10- to 12-week CBT groups on anger management, social skills or managing anxiety or depression (Lambert, 2004).

### *Influence of self-help groups*

Although the first self-help group, Alcoholics Anonymous (AA), was established in the 1930s, it is in the last 20 years that the self-help group movement has really taken off to become a major contributor to positive mental health. Yalom (1995) suggests that the thriving self-help group movement has replaced the encounter movement as the choice for the average person who is looking for the support and encouragement of peers that is to be found in the interpersonal interaction of groups. It is now possible to attend a self-help group for just about every problem or specific issue facing people, whether it is an alcohol or drug problem, being bereaved or affected by suicide, wishing to overcome shyness or recovering from major mental illness. For nearly every medical condition there is now an associated self-help group from which sufferers or their families can seek support. Self-help groups also bring together people who are stigmatised or alienated in society whether it is on account of being obese, black, gay, a single parent, or from any other minority. They are also a major source of support to people going through common life transitions such as being a new parent, being recently divorced or under-going retirement. In recent years huge numbers of people in North America have attended a self-help group. A recent study of graduate students in social work and clinical psychology found that nearly 40 per cent of them had personal experience with a self-help group (Meissen, et al. 1991). A comprehensive survey of the general population in North America in 1991 revealed that approximately 7 per cent of the adult population had attended a self-help group (Wuthnow, 1994). Given that

this figure is equivalent to or greater than the take up of professional therapeutic services it is arguable that self-help groups are as important as professional mental health services in providing support to the general public (Corey, 2000; Yalom, 1995).

There are many parallels and overlaps between the development of brief models of groupwork and the development of self-help groups. Both demonstrate the increasing value placed on clients solving problems from their own strengths as opposed to being dependent on a professional facilitator. Indeed, all therapeutic interpersonal groupwork could be conceived as having a 'self-help' component to it. The primary power of a mature or advanced therapy group is the influence of the members on each other. What counts is how members help one another. As we shall see in later chapters, the aim of the facilitator is to establish the conditions and trust in the group whereby clients can help one another and then to 'get out of the way to allow them to do it. There are also overlaps between brief groupwork and self-help groups and the distinction is often blurred. In a survey of self-help groups in North America it was found that between 70 and 80 per cent have some form of professional involvement, whether this is when they were being established or on a consultancy basis at different periods during their lifetime (Goodman and Jacobs, 1994). Conversely, many brief groups have gone on to become functioning self-help groups or have relied on clients from associated self-help groups to assist in their facilitation. Arguably, every brief group therapist should aim to transform the group they are facilitating into a self-led, self-help group – the ultimate in brief groupwork, having no professional involvement whatsoever!

### *Influence of solution-focused therapy*

Solution-focused therapy has its origins within the family therapy/systemic tradition and derives mainly from the work of de Shazer, Berg and their colleagues at the Brief Therapy Centre, Milwaukee, USA (de Shazer et al., 1986). It differs from many traditional therapies in that its focus is not on the problem, its cause and development, but on the solution, preferred futures and goals. Table 1.1 compares the assumptions which underpin problem-focused and solution-focused approaches to therapy.

When solution-focused therapy was developed the approach represented a paradigm shift from the largely pathology-centred therapies, which were prominent in psychotherapy. O'Hanlon and Weiner-Davies (1989) described the development as a 'megatrend' in psychotherapy: 'Stated simply, the trend is away from explanations, problems and pathology, and towards solutions, competence and capabilities' (1989: 6). This 'megatrend' is mirrored in many other developments in therapeutic methods which emphasise a strengths-based orientation such as narrative therapy

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Table 1.1 *Comparison of problem/pathology and solution/strengths approaches*

| Problem-focused   | Solution-focused   |
|---|--|
| Focuses on understanding fixed problem patterns in clients' lives.  | Focuses on understanding how change occurs in clients' lives, and what positive possibilities are open to them.  |
| Elicits detailed descriptions of problems and unwanted pasts.   | Elicits detailed descriptions of goals and preferred futures.  |
| Person is categorised by the problems and diagnoses they have.  | Person is seen as more than the problem, with unique talents and strengths and a personal story to be told.  |
| Focuses on identifying 'what's wrong', 'what's not working' and on deficits in individuals, families and communities. | Focuses on identifying 'what's right and what's working', on strengths, skills and resources in individuals, families and communities.   |
| Clients invariably resist change or therapy, and may prefer the secondary gains of the problem.                       | 'Resistance' is created when the therapeutic goals or methods, or the therapeutic alliance do not fit with the client. The onus is on the therapist to adapt therapy to the clients' goals, to their preferred method and to create a constructive alliance. |
| Therapy has to be long-term to create enduring change.  | Therapy can be brief in creating 'pivotal' change in clients' lives.   |
| Trauma invariably damages clients and predicts later pathology.   | Trauma is not predictive of pathology as it may weaken or <i>strengthen</i> the person. The therapist is interested in discovering how the client has coped with the trauma.   |
| Centrepiece of therapy is the treatment plan devised by the therapist who is the 'expert'.                            | Centrepiece of therapy is the clients' goals, coupled with their strengths, resources and expertise on their own lives, to move towards them.  |

*Source:* Parts of this table were adapted from Saleebey (1996).

(White and Epston, 1990), strengths-based approaches in social work (Saleebey, 1992), the resilience focus developed in family therapy (Walsh, 1996) and in recent formulations of cognitive behavioural therapy (Meichenbaum, 1996).

Since the development of the model, solution-focused therapy has been applied to groupwork in a range of settings and with a range of client populations, such as in schools with children and adolescents (LaFontain



et al., 1995), relaxation groups in mental health day centres (Schoor, 1995), patients in psychiatric hospital (Vaughn et al., 1996), parenting groups (Selekman, 1993) and perpetrators of domestic violence (Uken and Sebald, 1996). Solution-focused ideas have also been combined with other cognitive-behavioural models in anger management groups (Schoor, 1997) and parent training groups (Sharry, 2004a).

In my own view, it is the emphasis on a strengths-based collaborative style of working with clients that is the greatest contribution of solution-focused therapy and which has done much to balance the previous more pathological and problem-focused approaches. Such a strengths-based approach and the respectful collaborative style it engenders is particularly useful in engaging marginalised clients and clients who have been traditionally perceived as difficult or problematic within mental health services (see chapter 5 and 8).

### **The therapeutic factors of solution-focused groupwork**

It is one of the most beautiful compensations of this life that no man can sincerely try and help another without helping himself . . . . Serve and thou shall be served. (Ralph Waldo Emerson)

Within solution-focused therapy clients are seen as having most of the resources and strengths to solve their own problems (George et al., 1990). Therapy is ideally a process of empowerment, where clients are 'reconnected' to the resources that exist within their lives and encouraged to take charge of their own healing. Brief groupwork with its emphasis on bringing people together to support and encourage one another towards similar goals also espouses values of empowerment and self-healing, but gives members access not only to their own resources but also to those of other group members. In addition, individuals can bind together in groups and take on outside oppressive forces in society, which give rise to the problems, in ways that would not be possible alone. For example, in groups, members of a racial minority are in a better position to raise awareness and challenge any discrimination directed towards them.

In this way, solution-focused therapy is ideally situated within groupwork, as many of its principles resonate with the therapeutic factors inherent in groupwork. Yalom (1970, 1995) was one of the first theorists to analyse comprehensively the therapeutic factors inherent in group therapy which give rise to its unique power as distinct from individual therapy. Solution-focused groupwork can be conceived as aiming to 'activate' the therapeutic factors of groupwork. In a well-functioning solution-focused group the group dynamics have been harnessed in such a way as to work in harmony with the members in the pursuit of their goals. Yalom's original list of therapeutic factors applied to all types of groups. Given the

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brief and focused nature of solution-focused groupwork, different clusters of factors are prominent. These are listed in Table 1.2. The table includes Yalom's concept of 'existential factors' (facing the basic issues of life, death, freedom, isolation and meaning) though it has no obvious equivalent in solution-focused groupwork and also the factor of 'group empowerment' (whereby groups develop their own identity collectively to take action in the outside world), which has no simple equivalent in Yalom's original list. Below we describe each of the group therapeutic factors and their potential to contribute to client outcome. (In Chapter 3 we look at the role of the group facilitator in activating these therapeutic factors and consider the important group facilitation skills that are necessary which are in addition to the skills of the individual therapist.)

Table 1.2 *Therapeutic factors of groupwork*

| Solution-focused groupwork | Yalom's (1995) therapeutic factors  |
|----------------------------|---|
| Group support              | Universality (sense of not being only one)<br>Group cohesiveness<br>Catharsis   |
| Group learning             | Imparting of information<br>Interpersonal learning<br>Developing socialising techniques<br>Imitative behaviour<br>Corrective recapitulation of the primary family group |
| Group optimism             | Instillation of hope  |
| Opportunity to help others | Altruism  |
| Group empowerment          | <i>no equivalent</i>  |
| <i>no equivalent</i>       | Existential factors   |

*Group support*

Many clients come for professional help burdened by the idea that they are the 'only ones' with a particular problem. They feel blamed by others and frequently blame themselves. They often feel that their thoughts or feelings are unacceptable or shameful and shared by no one else. Such self-blame is an enormous block to therapeutic progress. The sense of universality that groups can bring is very powerful in alleviating this burden, often in a way that is not possible in individual work alone. For example, clients who have been bereaved can often harbour difficult-to-bear or unacceptable feelings. They can feel a great deal of anger at the lost loved one for having left or, more unacceptable still, they can even

feel great relief that the person is dead. Though such feelings are relatively common, clients can experience great guilt at having them and this can block any healing. In groups, clients can draw enormous support in realising that they are not alone in their experience, no matter how awful it is; it is great solace that other people have felt the same way. In fact one of the most common pieces of written feedback from clients who have completed group interventions is how relieved they felt when they realised they were 'not the only one'.

Group facilitators can use the great power of universality by designing specific issue groups that bring clients together who are coping with similar problems such as sexual abuse survivor groups, carers groups, bereavement groups, etc. Even in groups where there are cultural or other differences among members, the group facilitators can enhance the sense of universality by ensuring a common purpose in the group formation and by focusing on common experiences in facilitating the group.

The sense of being understood and accepted differs in a group context than in individual work, as within a group the client experiences this acceptance from fellow members as well as the facilitator. Clients may find it more powerful and a bigger boost to self-worth to be understood by their peers than by a professional facilitator alone. Equally, in a group there are many more personalities and different types of people. Clients are more likely to find someone on their wavelength in this mixture and there can be a richness and diversity in the types of relationships possible. In many brief groups clients have made friendships and alliances that have endured beyond the life of the group and which have been arguably more helpful than previous professional relationships.

### *Group learning*

Successful individual therapy generally involves a degree of learning on the part of the client, whether this is information supplied by the therapist (for example, many addiction counsellors provide information on the effects of drugs to their clients) or interpersonal learning, whereby the client becomes aware of how they personally relate to the therapist and can generalise this to outside relationships. A group setting can provide a more rich and diverse environment for learning and can have a more powerful impact on the individual.

Groups can afford a more empowering way for information to be imparted. On a one-to-one basis, the imparting of information can appear hierarchical and didactic and can take away from the normally facilitative therapeutic role of the professional. In a group, there is the opportunity for the discussion and debate of presented ideas. Members can feel more empowered to challenge ideas and thus not to take them at face value but to adapt them to their own life situation. Secondly, in a group setting

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members have the opportunity to learn from each other. Learning can become a shared collaborative endeavour, each person as well as the facilitator imparting information to the group.

The group setting also provides an excellent opportunity for interpersonal learning. Clients can gain insight into their relationships with others, both by relating differently themselves and by observing and learning from how others relate. In solution-focused groups, this is often achieved directly by the use of role-play or structured exercises. For example, when teaching communication skills, role-play could be used to give clients an experience of relating differently, with learning being reinforced by feedback from other group members. Equally, interpersonal learning could occur indirectly. Clients are indirectly learning from each other all the time as they experience and observe the interactions in the group. In a solution-focused group, the facilitator can build on this by focusing on positive patterns of communication in the group, drawing members' attention to them. For example, a facilitator could notice: 'I admire the way Jean spoke up then and clearly said what she thought, while also listening to Gerry.' Such a positive focus can enhance interpersonal learning.

From a solution-focused perspective the goal in groupwork is to create a culture of positive, supportive interpersonal communication among the group members. Many clients come from family or outside group situations that are problematic and stressful. The aim of solution-focused groupwork is not to repeat negative patterns of communication, for understanding or analysis, but to provide a positive exception to them. The group should become an enjoyable learning and therapeutic experience for members.

### *Group optimism*

Hope and optimism are essential preconditions to therapeutic change. Over and over again researchers have proven how expectation or hope of change on the part of the client or the therapist (commonly called placebo factors) can have a very powerful effect on outcome (Snyder et al., 1999). In clinical studies in the treatment of depression researchers have found that an inert placebo can be as powerful as psychoactive drugs, when patient and/or doctor believe that it is going to work (Greenberg and Fisher, 1997). So important is the instillation of hope, that Lambert (1992) in a widely cited survey of psychotherapy outcome estimated that placebo factors were *as important as* therapeutic technique and skill in creating a positive outcome (both accounting for 15 per cent of the variance in positive outcome).

Groups also afford unique ways to foster hope and the expectation of change, which are not available in individual work. The creation of a

group is often perceived as a dramatic event by clients; the fact that several people are coming together united in a common cause can instil more hope than a single person alone. Solution-focused group facilitators can capitalise on this fact by presenting the purpose of the group in a positive light to potential members. By emphasising the goals of the group and the strengths of the individual members a facilitator can build a strong belief in the potential of the group.

Secondly, in groups clients witness other people who are solving or who have solved problems similar to their own and this can give them great hope that such change is also possible in their own lives. Group facilitators can capitalise on this by ensuring that the primary orientation of the group is solution-focused, centred on how members cope with and solve problems and on their strength in overcoming limitations and surviving adversity. It can also be helpful to involve 'successful graduates' of previous groups in the running of subsequent ones. For example, in a college setting it can be very powerful to invite a student who successfully completed a previous group to be a co-facilitator. The other students are often more convinced by the experience of this person who is of a similar age and background to themselves. Hearing the student's positive and real account of change can inspire them to believe that change is also possible in their own lives.

#### *Opportunity to help others*

A not-so-obvious therapeutic factor in groupwork is the opportunity it affords group members to help others. As Yalom (1995: 12) notes:

Psychiatric patients beginning therapy are demoralized and possess a deep sense of having nothing of value to offer others. They have long considered themselves as burdens, and the experience of finding that they can be of importance to others is refreshing and boosts self-esteem.

The mutual help provided in groups can be a vast resource and an alternative to the 'expert' help of professionals. Indeed, group members are often much more likely to accept the support, suggestions and encouragement of other group members who are seen as on their level than that of the professional facilitator, who is seen as distinct from them. The act of helping benefits the helper as well as the helped. Rappaport et al. (1992) describe how the roles of group and organisational leadership are enormously beneficial to senior members of the GROW programme (a twelve-step self-help programme for former mental patients). Indeed they note that:

Members who provided more helping behaviors to others in the group meetings (assessed by detailed behavioral observations) showed both higher rates of attendance and greater improvement in social adjustment over time. (1992: 87)

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The opportunity to help others in groupwork gives members a chance to be of value and to contribute meaningfully to the group and thus be valued themselves. It also gives members a distraction from self-absorption in their own problems, and thus can give a new perspective. The act of helping necessitates listening to and focusing on the concerns of another; helping makes group members reach outside themselves to consider the position of another. By doing this they gain a different and often more grounded perspective on their own problems.

Group facilitators can enhance this therapeutic factor by collaboratively running groups with clients and by looking to involve them in all aspects of the group functioning, drawing on their strengths, resources and skills. This can be as simple as asking one group member to describe how he/she overcame a bout of depression to another member who is feeling low that day. Equally facilitators can ensure there are many roles of responsibility for members to take up in the design and facilitation of the group. Over time there may be an opportunity to step down from leadership and ultimately empower the group to run itself (perhaps stepping in from time to time as a consultant), thus allowing members to benefit maximally from the dual roles of helping and being helped.

### *Group empowerment*

Therapeutic groups can become powerful forces in their own right and can influence outside arenas within society at large. Group members with common experiences, bound together in a common purpose, can feel empowered to take on outside forces and to address the issues that they may not have been able to do alone. In addition, by being in a group with complementary resources, they can have much greater impact than as single individuals operating alone. Whether this is a group of women who have suffered domestic violence campaigning for better protective legislation and for change in societal attitudes, or whether it is a parents' group in a special school working together to promote an awareness of the needs of parents with disabled children and lobbying for better facilities, in both cases the group members have been empowered to take their cause outside the confines of the group to impact on wider issues.

Narrative therapists believe that many problems are caused by outside forces and should not be exclusively located within the individual (Madigan, 1998; White and Epston, 1990). For example, anorexia could be conceived as being created (or certainly propagated) by societal attitudes towards women in general and the female body in particular. If the problem is to be solved then the individual needs to be empowered to take on and challenge these distorted ideas which permeate society. Empowerment is about externalising the problem outside the individual and locating its cause in oppressive discourses and ideas that support it.

Narrative therapists have discovered that groups can provide a powerful arena for this process to take place. By bringing people affected by the same problems together, powerful 'think tanks' can be established where members share ideas and generate new descriptions and knowledge about the problem which they can then take outside the group to challenge existing prejudices reinforcing the problem's influence. Like the self-help movement this knowledge can have far-reaching consequences and can be of great benefit to other people affected by the problem. This is the purpose of the Anti-Anorexia League (Grieves, 1998; Madigan, 1998) and the 'Power to Our Journeys' group established by the Dulwich Centre Community Mental Health Project (Brigitte et al., 1997). 'The Power to Our Journeys' group consists of a group of women affected by schizophrenia, who have published documents both on their experiences of schizophrenia and how they have managed to overcome its negative effects. The documents communicate their unique experience and are published as a sign of them taking back control of their lives and in support of other people affected by schizophrenia. In addition, the members of the group act as consultants to the mental health project and they invite contact from similar groups worldwide (Brigitte et al., 1997).

### **Research evidence for the effectiveness of groupwork**

#### *Is groupwork generally effective when compared to equivalent individual work?*

Though therapeutic groupwork is a broad category including diverse models and approaches, there is a general consensus in the research literature that groupwork is an effective intervention. On average clients receive significantly more benefit by attending a therapeutic group than by being part of a minimal treatment control group and this conclusion is duplicated in numerous studies and borne out in meta-analyses (Bednar and Kaul, 1994).

A second question, which is perhaps more burning for practitioners, is whether groupwork is more effective than equivalent individual work. Smith et al. (1980) in their famous meta-study of psychotherapy research found that group therapy was as effective as individual therapy. Toseland and Siporin (1986) in another meta-study reviewed 32 comparison studies and found group therapy to be more effective than individual therapy in 25 per cent of the studies and for both modalities to be comparable in outcome in the remaining 75 per cent. McRoberts et al. (1998) in a more recent meta-review of 23 outcome studies found no difference in outcome between the group and individual formats.

In summary, we can conclude that generally groupwork is as effective as individual work and in some instances may actually be more effective.

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This means of course that conclusively groupwork is a more cost-effective intervention, given that many more clients are helped via groupwork for the same amount of therapist input (or indeed with no therapist input in the case of many self-help groups). Of course it would be naïve to suggest that groupwork should replace individual work. For many clients groupwork is not an option, in that they prefer individual work or the group setting would not meet their needs. In addition many group formats depend on individual work. For example it may be necessary to have a screening interview or a number of preparatory or parallel sessions to facilitate the group intervention being taken up. It is more fair to conceive the modalities of treatment as complementary and interdependent on one another. Providing the option of either individual or groupwork or both to clients is perhaps the best way to maximise outcome.

*Is brief groupwork effective?*

In order to cope with the large numbers of clients referred for long-term group psychotherapy, Malamud and Machover (1965) arranged 15-session preparatory groups for up to 30 patients to prepare them for the subsequent group therapy. The researchers were interested in establishing whether the group preparation had a positive effect on group outcome for the subsequent group therapy. Not only was this found to be true, but many of the patients *had made substantial gains in the preparatory groups deeming it unnecessary for them to start the long-term group therapy*. Thus inadvertently the researchers gave an endorsement of brief groupwork.

With the emergence of brief groupwork as a modality in its own right during the 1980s and 1990s, researchers have begun to study its effectiveness. In their review of research Rosenberg and Zimet (1995) found strong evidence that time-limited out-patient group therapy was effective for behavioural, cognitive-behavioural and psychodynamic approaches. Currently, the majority of groupwork being conducted worldwide within mental health services (with the exception of mainland Europe) is now brief groupwork (up to 12 sessions), that is issue-focused (e.g managing depression or anxiety) and employing a brief model such as Cognitive Behavioural Therapy (CBT). The majority of recent meta-studies providing support for groupwork are drawn from relatively brief groupwork interventions (Burlingame et al., 2004).

*How important is group process in outcome?*

A large proportion of the studies that provide the evidence for the effectiveness of groupwork based their approach on the inherent individual psychotherapy model and did not formally attend to group process



principles in the delivery of the therapy (Burlingame et al., 2004). Thus it is not clear from some studies whether it is the individual therapy model or the group therapeutic factors which contribute most to the outcome. As discussed in the last section, a major contention of this book (and others e.g. Yalom, 1970, 1995) is that group therapy has several therapeutic factors that make it distinct from individual therapy, and give rise to its unique therapeutic power. In a nutshell, group therapy is conceived as much more than doing 'individual therapy in front of a group'. The question remains as to whether this confidence in the therapeutic factors of groupwork is supported in the research evidence.

Though there is a lack of systematic research in this area, there is a growing body of evidence supporting the importance of group process principles. To begin with, Burlingame et al.'s (2004) review highlighted a significant number of studies which showed that control groups (which involved group discussion and support) rivalled the outcome of active treatment groups that used a specific therapeutic model (e.g. CBT). The finding was replicated across a number of client populations such as mood disorder and social phobia, thus suggesting that group process principles are as powerful as a formal model of change. Moreover, there is a large amount of evidence to show that self-help groups and groups led by para-professionals (which mainly draw on group process as the agent of change) are equivalent in outcome when compared with professionally led groups employing specific therapy models (Beutler et al., 1993; Burlingame and Barlow, 1996; Heimberg et al., 1990). A more recent wave of research has actually begun to link specific processes unique to the group format to outcome. For example, studies of cognitive behavioural groups that pay explicit attention to group process strategies have found processes such as cohesion and member participation to be predictive of improvement (Castonguay et al., 1998; Glass and Arnkoff, 2000). Concluding their comprehensive review of the research, Burlingame et al. (2004) recommend that greater attention should be given to the impact of specific group processes on outcome and called for much more research in the area.

*Are solution-focused or strengths-based approaches to groupwork effective?*

Though solution-focused therapy (SFT) in general and solution-focused groupwork in particular are relatively new developments, there is a growing body of research to suggest their effectiveness. A randomised comparison study comparing the effects of short-term psychodynamic psychotherapy and SFT with clients with depressive and anxiety disorders showed that both therapies were comparably effective with some evidence that SFT achieved results in fewer sessions (average 10 sessions over 7.5 months compared to 15 sessions over 5.7 months) (Maljanen et al., 2005). There

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is also evidence that SFT may be effective with clients traditionally perceived as 'difficult to engage' within services. For example, a randomised study showed reduced reoffending rates for prisoners offered 5 sessions of SFT compared to a control group (60 per cent as opposed to 86 per cent at 16-month follow-up) (Lindfors and Magnusson, 1997). Also, in a comparison study in the USA of occupational rehabilitation programmes, Cockburn et al. (1997) showed that clients offered SFT were more likely to return to work compared with the standard rehabilitation package (68 per cent compared with 4 per cent).

There is also similar evidence for solution-focused group interventions. A study of six-session solution-focused parenting groups found parenting skills were significantly improved in treatment compared to a waiting list control group (Zimmerman et al., 1996). Students who completed solution-focused counselling groups were found to have significantly higher levels of self-esteem and more appropriate coping behaviour than students in a waiting list control group. In addition the solution-focused counsellors reported less 'exhaustion' and depersonalisation on one-year follow-up (LaFontain and Garner, 1996; LaFontain et al., 1996). Once again there is also evidence for solution-focused approaches with clients who are traditionally hard to engage in therapy. In a study of two separate projects using a solution-focused group intervention with 151 perpetrators of domestic violence treatment, only seven clients (4.6 per cent) had re-offended on completion of the programme and in a six-year follow-up recidivism rates for the clients amounted to 17 per cent (Lee et al., 2003). These results are very impressive when compared to recidivism rates at five-year follow-up for traditional treatments which are as high as 40 per cent (Shepard, 1992).

An interesting smaller study of a primarily solution-focused couple-based treatment for domestic violence compared individual delivery of the treatment ( $N = 14$ ) with a multi-couple group delivery ( $N = 16$ ) and with a no treatment control group ( $N = 9$ ) (Stith et al., 2004). Male violence recidivism at six-months follow-up were significantly lower for the group treatment (25 per cent as opposed to 43 per cent for individual and 66 per cent for the control group) and the multi-couple group showed significantly higher levels of marital satisfaction than both other groups. This study not only indicates further evidence for the SFT approach, it also highlights how group therapeutic factors may enhance the outcome.

In summary, there is evidence that solution-focused approaches are at least as effective as traditional approaches (with some evidence that they require fewer sessions) and the approach have been successfully delivered within groupwork formats. There is also evidence to suggest that the solution-focused approach may have particular success with clients traditionally seen as 'difficult' or hard to engage in services. It is my own belief that it is the collaborative strengths-based principles that underpin

the approach that contribute to this specific success. These principles are not unique to solution-focused therapy and many practitioners in traditional therapies have argued for a shift to these principles. For example, in the editorial of the *British Journal of Psychiatry*, Fonagy and Bateman (2006) have challenged the pessimism attached to the treatment of clients with borderline personality disorder, arguing that much of the poor outcome is attributed to the confrontational approach of some therapies, and that a non-expert collaborative and flexible style (in line with strengths-based principles) is more likely to lead to better outcome.

Similarly, in reviewing the reasons why many marginalised parents have not succeeded at traditional parent training, Webster-Stratton (1998) has argued against pathologising parents for these difficulties and instead argued for more client-centred, collaborative approaches – ‘Perhaps this population has been “unreachable” not because of their own characteristics, but because of the characteristics of the interventions they have been offered’ (1998: 184).

### Summary

Solution-focused groupwork has emerged within recent years as a realistic model for structuring therapeutic interventions. Its emergence reflects a growing consumer and cultural preference for strengths-based and briefer forms of therapy. The approach works by activating the therapeutic power inherent in bringing groups of people together to help one another, giving rise to increased optimism, support and learning. This empowers members individually and collectively to take action. Though solution-focused groupwork is a relatively new development, there is a growing body of research to suggest its effectiveness as a therapeutic intervention, particularly with clients who are traditionally perceived as hard to engage. In addition, the approach arguably has a number of positive implications for practice in that it presents a strengths-based collaborative way of working, which makes the best use of the resources to which clients and professionals have access.