Effectiveness of group therapy

This chapter presents a review of some of the major theoretical approaches, which attempt to examine the effectiveness of therapy of group and family contribution in the treatment process. Thus we will look at, existing studies and support on group therapy as an effective method of treatment, and, family contribution to a substance addict individual, and family therapy.

“ By the crowd they have been broken; by the crowd they must be healed.” (Tedeschi, 1998)

This psychiatric maxim is nowhere more applicable than in the treatment of alcoholism. The rapidly increasing use of groups’ treatment of psychological disorder, for personal growth, and for learning of adaptive social skill is one of the most important mental health developments in today’s world. Despite the potential benefits of individual therapy, Stinchfield, Owen and Winters (1994) indicate that group therapy is the most common form for substance abusers and dependents. There are now robust research findings showing the effectiveness of dynamic groups as a powerful intervention for a number of disorders, including depression, personality disorder and anxiety states (Robinson et al, 1990; Budman et al, 1998). Group therapy as a psychological follow up refers to putting into practice theories or, commonly a therapeutic session based on individual commitment to motivate one and others to live a sober life, with a spirituality help like practice by AA. Groups generate positive peer pressure, support and accountability for healthy changes that have no parallel in individual therapy. It is very important to have a group leader, so that proper guidance is given, therapeutic confrontation and realistic feedback can be provided too.

The growing use of group therapy can be based on Alfred Adler principles of Individual Psychology. The basic doctrine of Adler is that " human creatures are social creatures who need corrective and supportive attention from others; and that their psychological illnesses are due to excessive self-absorption to the neglect of social interest" (cited in Lakin, 1984). Thus, the interaction in group therapy fosters the development of this social interest (Papanek, 1970). Negativism and antisocial acting out could also be lessened through experiencing the inherent needs for belongingness and social approval in the groups (Lakin, 1984). The individual learns from the reactions of other participants how to express his own innate potential social interest through helping others. The social commitment of a successfully treated individual replaces self-defeating asocial and antisocial modes of being in the world.

Phenomenologist argues that therapeutic group is a ' mirror phenomena' which confronts individuals with various aspect of his social, psychological or body image. It can be assumed that a member of any therapeutic group has a disturbed emotional upbringing that continues to influence his behaviour in adulthood. The mirror reaction in the group help to counter act this morbid self-reference. By sympathizing and understanding, by identifying with, and imitating, by externalizing what is inside and by internalizing what is outside, the individual activates within himself the deep social responses that lead to his definition, in the first place as a social being.

An important curative factor that should exist in group therapy is " cohesiveness". Cohesiveness is that force that acts on all the members such that they remain in group or more simply, the attractiveness of a group for its members (Irvin. D Yalom, 2005). In their research paper, on ' Group therapeutic factors on an alcohol in-patient unit', Lovett & Lovett (1991) found that patients valued most an existential factor, self-understanding and cohesiveness; they least valued guidance and identification In this respect, the creation of a climate that fosters understanding of self, and self in relation to others helps group members understand the ways in which their narcissistic vulnerabilities and difficulties lead to attachment to alcohol use (Reading & Weegmann, 2004).

Therapy groups are well suited in addressing the interpersonal manifestation of psychological difficulty. Therefore, goals established prior to therapy are usually couched in interpersonal language such as dealing with the loss of a developing relationship, or learning to be more assertive (Mc Kenzie, 1997). Kohut (1984) suggested a firm sense of self is established as the group members work through their individual differences in groups and learn more adaptive ways of resolving interpersonal and intrapersonal conflicts. The group enhances this process because it supplies each member with a source of support, identification and acceptance while at the same time giving each individual a set of healthy values that can be internalized and incorporated.

To properly understand how cure is obtained in a therapy group, there are several curative factors operating, as listed below:

Altruism. The feeling that a member is helping others and is important in their lives. Patients forgot themselves momentarily, at least and focus on helping others. People need to feel that they are needed.

Catharsis. Expressing positive and negative feelings towards other members and the group leader. Acceptance for openness and personal change as a result of trying out new behaviours begins to emerge. Feelings are no longer held inside.

Existential factors. Individual learn that there are limits in the world and that they alone are responsible for their life.

Identification. Individual learns vicariously by watching and listening others in group.

Instillation of hope. Seeing others getting better, knowing that the group has helped, give members faith in the treatment mode.

Interpersonal Input and Output. Seeing how ones relate to others and how others relate to one, and then working to satisfy interpersonal relationship. Also, when feelings are expressed openly, the group is supportive.

Universality. Feeling that one is not that different from others. “ We are all in the same boat”. As common denominators emerge, support occurs.

(Source: Yalom, 1975 cited in Flores, 1997)

Group psychotherapy is a corrective for addictive vulnerability because a human context is created for patient with substance use disorders to play out and re-enact their self-regulation problems, with affects, self-esteem,

relationship and self-care as well as the characterologic defenses that disguise and betray them (Reading & Weegmann, 2004). Suffering is at the core of addictive vulnerability. However, the worst fate is not simply to suffer, but is to suffer alone (Khantzian, 1999). In group therapy, members know that they can count on the other patients in trying actively to recovery from their weakness and pain.

2. 2. Effectiveness of AA as a Group Therapeutic alternative.

" Once an alcoholic, always an alcoholic" (Bill Wilson & Dr Robert Smith, 1939, ' The Big Book')

One of the many reasons that could explain why the AA continues to dominate alcoholism treatment lies in this expression. For the Alcoholic Anonymous, there is no such thing that we call " controlled drinking". In his book entitled " Getting started in AA", B. Hamilton (1995), put forward that there have been no research studies which had shown that an alcoholic could control their drinking. They could have tried but eventually they failed. Still in his book, Hamilton mentioned that there are no forms of treatment which have ever permitted an alcoholic to return to normal drinking. Even competent medical experts are unanimous on the issue that the only treatment for alcoholism is abstinence. Thus, to abstain from alcoholism, AA members count a lot on spirituality and helping their other members in staying sober.

Several studies have also suggested that AA-facilitated abstinence is partly due to an increase in self-efficacy which arises from its recovery program (Project MATCH 173 Research Group, 1997; Tonigan and Connors 2008). AA

provides a new social network supportive of abstinence; for the patient who lacks such support in their home environment, this aspect of AA involvement plays an important role in relapse prevention (Bond et al. 2003; Litt et al. 2007; Vaillant, 2005).

Alcoholic Anonymous achieved a remarkable success rate. In his book entitled, Big Book- A Young person guide to Alcoholic Anonymous-, John. R (2003) said that of all the alcoholics that came to AA and really tried, 50% got sober at once and remained that way; 25% sobered up after some relapses, and among the remainders, those who stayed in AA, showed improvement. As Riessman and Gartner (1979) argued in support of such a helping group, their effectiveness lies in the fact that the patients have a fuller, more determining role in the helping process (cited in Lakin, 1984). Moreover Alcoholic Anonymous provides a network of stable individual and group relationship which powerfully impact on the governance of the drinking behaviour (Khantzian & Mack, 1994). Effectiveness can be resulted by the importance placed on the following

2. 2. 1. Attendance

Erikson (1976) referred meetings to a culturally patterned way to experience the daily interaction of individuals. In some way, its aim is to renew a sense of community and to restore the individual's status as a member of the group (Turner, 1974). Taken from Strobble (2009, p. 82), earlier studies across a number of alcohol treatment samples have reported positive relationships between AA meeting attendance and drinking outcomes (Thurstin, Alfano & Nerviano, 1987)-most notably abstinence-while others failed to find such relationships, or reported mixed results (McLatchie &

Lomp, 1988; Miller, Leckman, Delaney & Tinkcom, 1992). Two meta-analyses (Emrick, Tonigan, Montgomery & Little, 1993; Tonigan, Toscova & Miller, 1996) and Project MATCH (Tonigan et al., 2003) each reported modest, positive associations. In light of varied results, it has been suggested that AA meeting attendance may be " an indirect reflection" of other important processes that are more strongly related to outcomes, and that attendance by itself may not indicate " genuine involvement" (Montgomery, Miller & Tonigan, 1995).

2. 2. 2. Help given to the afflicted by the afflicted

AA comes along with this perception of, in order to alleviate the psychological suffering and to improve coping abilities of an alcoholic; the solution will come from experiences of the afflicted rather from the expertise of the healer (cited in Lakin, 1984, p. 183). This does not mean that, they are completely against the use of professional idea but for AA members, peers who have themselves suffered and who are trying to overcome their problems are in better position to understand, and thus render effective psychological aid to others in similar circumstances. Therefore, the responsibility for the conduct has been vested in the members themselves rather than professional mental health organization. In a study on the ' helpfulness of different parts of AA meetings' upon 171 participants 75% found that discussion in group as very helpful and 14. 9% as fairly helpful (cited in D. Robinson p. 63). Sharing, support and encouragement that members give to each other are of great value for AA.

2. 3. Alcoholism as a family disease.

Substance abuse has often been described as a “ family disease” (e. g. Goodwin & Warnock 1991). There are approximately 13 millions alcoholics in the United States; at least 4 millions others are affected intimately (APA 2000, cited in Carpenito-Moyer, 2008, p. 734). The familial nature of alcohol use disorders is likely to reflect both the influence of specific genes and negative environmental or psychological influences (Chassin et al., 1993; Colder and Chassin, 1999; Moos and Billings, 1982; Sher et al., 1991; Smith et al., 1995; Tarter et al., 1999). The risk for alcoholism for sons of alcoholic fathers is around 25% (Pollock et al., 1987; Merinkangas, 1990) and the familial link is weaker for women (Muetzell, 1995). This risk of developing is estimated to be seven times greater amongst first degree relatives of alcoholic and this apparent genetic predisposition has been found mostly for alcoholism rather than other substance use (Bierut et al., 1998).

Moreover, when alcohol is being talked as a family disease this imply also the kind of environment in which someone is raised. Substance abuse generally develops within a context where one includes alcohol use and abuse by parents and siblings (Heath & Stanton, 1998). The families of substance abusers are often characterized by other problems including high degree of conflict, chaos, and children’s behaviour. (Sher, 1997). In some way, there is a breakdown in the good tradition, if we can say it like that, of a stable family. Recent data suggest that approximately one child in every four (28. 6%) in the United States is exposed to alcohol abuse or dependence in the family. Thus, in such environment there is poor communication amongst family members (Murphy & O’Farell, 1996), marital breakdown (Kosten et al.

1983), domestic violence (Benett, 1995) and child abuse or neglect, and physical and emotional abuse (Sheridan, 1995).

Therefore, there is clear evidence that alcoholic problems do have an impact on the psychological and physical health of the abuser but also on the nonusing family members. Cook et al. (1992), found that alcoholic with more serious dependence have more alcohol-related medical complications and that the spouses and children also have higher level of psychological symptomatology (Hinkin & Kahn, 1995). In summarizing a large body of research, indicate that families of individuals with alcoholism have increased use of health care services (e. g Robert & Blunt, 1982; Holder, 1998).

If the physical and psychological problems of the family members as well as those of the alcoholics are not addressed, the effectiveness of the treatment may be compromised (Gil-Rivas et al., 1997; Stanton, 1997). It is critically important for the entire family to be included in the treatment process at the same time. Not doing so can delay not only the alcoholic progress, but can delay the treatment of the family. Alcoholics who are more likely to recover are those who have the support and involvement of their family and significant others. The more the family knows and the healthier it becomes through treatment, the best the alcoholic and the family will recover together.

2. 4. Family in the process of rehabilitation

Alcoholics and addicts crave the approval of their families and friends. Generally speaking, we will see the family as a group which experience their strongest love and strongest hate, enjoy their deepest satisfaction and their

deepest disappointments (Glick et al., 2000). Outwardly, they may act as if they don’t need anyone and push them away to protect their addiction and hide their shame. Such behaviour does not mean that they don’t care for them anymore (Jay et al., 2008). In fact, it is by giving the alcoholics what they really want i. e. love, appreciation and respect that we can persuade them to accept treatment as the right thing to do. To adopt the right behaviour towards the alcoholic, and make change together with him are the effective techniques that the families can used to help a loved one suffering from this substance dependency. The family members develop more or less adequate understanding of another, collaborating in establishing consensus and to negotiate uncertainties (Handel and Whitchurch, 1994).

Analyses across studies of the effectiveness of spouse and family involvement in the treatment for alcohol demonstrate that including them enhances treatment effectiveness (O’Farell et al., 2000). Hurcom, Copello and Orford (2000), described how spouses tried to cope with their husband drinking behaviour. Three-factor model have been espoused where in one condition the wife is assertive, emotional, and supportive to change husband’s drinking. In another condition, there is a self-sacrifice and inactivity by the wife of the alcoholic which the called tolerance and finally, there is withdrawal where the wife ignore completely avoids the drunker and deal in independent activities. The avoidant or withdrawal coping styles tend to have negative consequences as the man go deep in alcoholism whereas assertive anti-alcohol messages by the spouses show a reduction in the level of drinking (Hurcom et al., 2000).

The family system model which was of great influence to the field of alcoholism in the 1970's, lead to some hypothetical suggestions that alcohol performed certain positive function in the family called " adaptive consequences of alcoholism", by stabilizing family roles, allowing expression of affect, and allowing for greater exploration of topics that family could avoid when sober (Steinglass, Davis & Berenson, 1977). In his observational studies, Steinglass found that families with a sober alcoholic were more flexible in their functioning, having a balance with time spend together and apart whereas drinking families showed most rigidity of family roles and interactions (cited in Rotgers, Morgenstern & Walters, 2001, pp. 116). Hence, the family systems perspective is typified by interventions that focus on the interpersonal relationships and communicative transactions to improve family functioning as a primary goal (Lawson et al., 1983). By changing the way that the family operates, it is assumed that alcohol will no longer function as a homeostatic maintaining force, which in turn, will result in a change in drinking behaviour (Lipps, 1999 cited in James. G Chan, ' The family Journal', 2000, p. 131).

In a meta-analysis, Edwards and Steinglass (1995) described four family interventions whereby treatment may become effective. They made analysis of the discussion and game playing on AA or Al-anon meetings or recreational activities and found that there was improvement in relationship. Moreover, a focus on the expression of feelings and the improvement of communication and problem solving were good as well as when the couples discussed how alcohol affected their marriage, or even how each contribute to worsen the situation and bring about solution to alleviate it in some kind

add to make the situation better (cited in James Chan, 2000, p. 131). The concept of “ stuck togetherness” was used to describe how alcoholism pulls family in terms of crisis or tension, however this same concept may be utilised in alcoholism treatment so that better educational indicative may be given to family about how family work, reducing the level of anxiety in the family, and promoting differentiation in all family members (Bowen, 1974; Lawson et al., 1983).

Many researches have been done on the behaviour family approach (BFA). This is a different type of intervention to family system approach. BFA is based on the concepts of operant and classical conditioning in the development of alcoholism in the context of the family (Miller and Heather, 1998, p. 272). Thus, the family is believed to give back pleasant and relaxing physiological effect to alcoholic, by using reinforcers such as providing attention (through nagging about current or previous drinking) or caretaking i. e. protecting the alcoholic from negatives consequences of his actions (cited in Chan, 2000, p. 133). Collins (1990) argued that the general therapeutic goal of BFA, then, is to reinforce positive interactions amongst the family members and decrease negative behaviour or interactions associated with drinking.

Alcohol behavioural marital therapy (BMT) is an outpatient intervention that regards alcoholic and non-alcoholic spouse as equal in the treatment process. In other words, BMT sees the substance-abusing patient with the spouse to build support for sobriety. Moreover, spouses are trained to decrease behaviour that cue drinking, and to avoid protecting the alcoholic from consequences of drinking e. g. calling the employer of the alcoholic

husband and look for excuses for him for his absence at work (Chan, 2000, p. 133). BMT involved increasing positive behaviour through rehearsal and recognized the importance of interplay between the behaviour and environment. The studies show a fairly consistent pattern of more abstinence and fewer alcohol-related problems, happier relationships, and lower risk of marital separation for alcoholic patients who receive BMT than for patients who receive only individual treatment (O'Farrell et al., 1992 cited in O'Farell, 1999, Journal of Psychosocial Rehabilitation, online extract).

Marital and family treatment approaches for addictive behaviour have been widely embraced in community mental health agencies and clinical setting and have received several outcomes evaluating the effectiveness of treatment for alcohol problems. Several reviews of family-based intervention have shown that family therapy is an effective technique for both adult and adolescent with substance disorder (Miller & Heather, 1998, p. 272) and it is associated with high rates of treatment engagement and retention, significant reductions in substance use and improved functioning in other behavioural domains (O'Farell, 1995; Waldron, 1997).

Other family-involved approach treatment to alcoholism also works for the benefits of the alcoholic and the family too. Al-Anon is an Alcoholic Anonymous affiliated support group for those who are distraught by another family member's alcoholism. Its aim is to encourage family members to detach themselves from the alcoholic's drinking behaviour and to focus on fulfilling their own areas of interest and satisfaction (Collins, 1990). Moreover, they also learn about the disease of what constitute alcohol and how their concern alcoholic relative suffer from that so that, the parents are

better armed to help them and be more comprehensive of the situation. However, despite the here say of the good work of Al-anon, researches did not consider it a lot since no empirical studies have been able to be carried out. This is because Al-anon is a close group too.

2. 5. Alcohol relapses: A bump in the road.

There are situations in the life of a recovering alcoholic patient where he has to face occasions where drinking is involved or even go to places where bottles of beers are being shared, and successfully deal with it or not. Going to the very best rehabilitation centres or the very well-known therapist, or even ones had stay sober for 20 years, does not mean that they won't experienced slip or relapse. A slip is an episode of AOD (alcohol and other drug) use following a period of abstinence while a relapse is the return to uncontrolled AOD use following a period of abstinence (Fisher & Harrison, 2005, p. 156). A recent survey showed that around 80% of alcoholics succumb to an alcoholism relapse once in a period of 4 years after the treatment is over.

The disease model of addiction and AA slogans- an alcoholic always " one drink from a drunk"- can promote the idea that a slip inevitably lead to a relapse. The rational lies behind the view adopted by therapists, AA members or those well acquainted with alcoholism prefer to use the term " recovering alcoholic," rather that " recovered alcoholic." This is because recovering alcoholic is reminded that one is not cure from alcoholism. For medical reason, since the body had been used to heavy drinking, the body biological memory of alcoholism remains intact, even if the recovering individual has " forgotten" (Kinney & Leaton, 1991, p. 226). Therefore, the

addiction can be rapidly reinstated and the alcohol dependent who resumes drinking may within a week be drinking in quantities equal to amount prior to abstinence.

In addition to that there are studies who reveal that there may be condition where relapse is being provoked. Stewart and De Wit (1987) stated that the acute re-exposure to the addictive drug itself is a potent event for provoking relapse to AOD seeking (cited in Al Absi, 2007, p. 28). Again, exposure to stress (Wills and Shiffman, 1985), or simply presentation of stress-related imagery (Li et al., 2005), is another event that induces craving or relapse in humans. Thus, disturbance in the emotional state may increase the consumptive aspect so that to regulate this tension or pressure.

From a psychological view, relapse deals mostly with characteristics such as feelings of disappointment, failure and frustration. If we consider slip, this means a complete deterioration to pre-treatment levels of functioning. Now, if there is not enough condition to support the client, when the slip occurs the recovering alcoholic may experience guilt, anxiety and hopelessness (Fisher & Harrison, 2005, p. 156). A feeling of guilt for having failed which lead to blaming oneself and a feeling of shame for having deceived those people who were there to support him. These negative emotions may lead to further, heavier use of AOD and back to alcoholism. Here, the cognitive process of the individual may go something like (I'm bad since I returned back to the starting point). So, it is very important to improve the self-esteem of the alcoholic so that there is a hope of a change in behaviour and back to treatment.

In a study done by Prasanthi et al. (2010) in India on " family member involvement in relapse prevention improves alcohol dependence outcomes", the findings reveal the effectiveness of family members' involvement in a relapse prevention intervention for alcohol-dependent individuals in India. The findings are in accordance with earlier research, which documented that including family support in treatment favorably affects outcomes in alcoholic individuals (McCrady et al., 2002; Neto et al., 2008; Walitzer and Dermen, 2004). Research by Mohd Taib, Rusli and Mohd Khairi (2000) on family communication patterns amongst addicts' family and non addicts' family, showed weak communication patterns and less effective interactions would only failed the rehabilitation process and in the long run caused the former addicts to relapse (cited in Ibrahim & Kumaar, 2009, ' Factors Effecting Drug Relapse in Malaysia: An Empirical Evidence, p. 38).