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Driving and restrictive factors of group practice in community psychosocial care services

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Abstract *This qualitative research aimed to investigate workers' theoretical conceptions regarding group work and analyze the driving and restrictive factors of group therapeutic practice in Psychosocial Care Centers (CAPS). Sixty-six workers from CAPS and outpatient clinics from the Psychosocial Care Network from twenty-three municipalities in the State of Goiás participated in the study. Data were collected through a structured questionnaire and a group interview audio-recorded and documented with photographs. The concept of what the group is and is not emerged from the thematic analysis of the data. The categories were organized into three analysis blocks concerning driving and restrictive forces: service-related, professional-related, and user-related. Relational, structural, and therapeutic aspects and professional competence for group coordination are integrated in an antagonistic, complementary, and inseparable way to apprehend the studied reality. We conclude that highlighting the restrictive aspects that must be recognized and improved and the drivers that must be maintained and enhanced can actively contribute to expanding the therapeutic capacity related to the use of group technology in mental health.*

Key words *Group processes, Professional practice, Group structure, Mental health services, Mental health*

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Introduction

The intersection between Group Dynamics and Mental Health is historical and is aligned with the emergence of new care modalities. Expressive and communicative practices related to artistic creation, income-generating activities, literacy, and physical skills are often offered as therapeutic group workshops. Furthermore, several strategies are also offered through groups, such as family care, group psychotherapies, and service assemblies[1].

It is evident that the group is a light technology of priority and central care in CAPS due to its multiple application possibilities, a wide range of therapeutic results, as it allows simultaneous access of several users to the service and is a robust, low-cost application technology[2]. Group therapies in mental health are essential in assisting service users as they allow comprehensive attention to the various demands of psychological distress[3]. In the group context, both the health process – mental illness, and the recognition of the realities and experiences of each user are worked on in a reflection-action-reflection process, which allows understanding the problems and particularities of each person and the group[2].

The workshops are a liberating and educational group care modality conducted under the guidance of one or more professionals from the team, accompanied by monitors or interns. Its modalities are defined according to the interests of users and the multiple possibilities of human resources and matters of the services[1,4]. They aim to include CAPS users in work, art, and craft activities and give them access to verbal and non-verbal means of expression on various topics, such as love relationships, friendships, work, sexuality, family, leisure, culture, and health[5]. This group therapy modality facilitates psychosocial interventions through the link between users and between them and the service workers, besides monitoring the development of the participants' clinical cases[5-7]. Therapeutic workshops can produce numerous benefits for CAPS users, such as socialization, building leadership, and social inclusion, the expression of subjectivity in indirect ways (mediated by art and culture), the expression of ideas and emotions that do not occur verbally and consciously, the decreased use of medications and better sleep patterns[6,7].

The nature of a group is defined by its structure, process, and content[8]. The group process enables understanding the group as a dynamic and complex totality organizing itself as a field of forces acting in opposite directions. Some forces drive the group's development and activity level, while some restrictive forces negatively influence group movement, decreasing production and even leading to group disintegration[9-12]. Identifying and analyzing the driving and restricting forces that act in the group field is one of the most potent applications of Group Technology, as the diagnosis of group forces enables the planning of actions to change and solve group problems in the group.

Driving forces are the favorable institutional climate, democratic and participative leadership, participant commitment, trust, affection in relationships, and the coordinator's technical competence for the group's task. In contrast, some restricting and limiting factors to group life are the excessive demands, pressure for results, communication problems, disorganization, lack of planning, centralization, and authoritarianism, to name a few [10,11,13].

Knowing how to identify the strengths in the group facilitates the search for new possibilities in the strengthening, potentiation, and transformations in the group dynamics. When the field of forces is revealed, the subject and the group are shown their current situation, generating awareness, empowering, and strengthening the individual through self-development[13,14]. Given the above, this study aimed to investigate the theoretical conceptions of workers about the group and analyze the driving and restrictive factors of group therapeutic practice in Psychosocial Care Centers.

Methods

This qualitative, descriptive, and exploratory research is nested in a more extensive investigation entitled "Qualify(action) of professionals from psychosocial care centers for the use of group technology"[15], approved by the Research Ethics Committee of the University Federal de Goiás, with initial protocol Nº 821.767 and final protocol Nº 3.951.500. The steps recommended for disseminating qualitative studies (COREQ) were used to conduct the research[16].

The study included 66 workers from Psychosocial Care Centers (CAPS) and outpatient clinics of the Psychosocial Care Network (RAPS) from 23 municipalities in the State of Goiás that met the following inclusion criteria: having completed higher education and being in professional practice in services during the research. Work-

ers who were away from work at the time of data collection were excluded from the study.

Data were collected in two stages. First, through a structured questionnaire sent by email so that participants could respond collaboratively with their work teams in the service. The instrument contained the following questions: Which groups are offered in the service? Which professionals lead the groups? Are some theoretical materials, studies, books, websites used to guide the development of the groups? If so, which one? Have you and the other professionals on your team who form groups already trained in the use of group technology? If so, which one? Where and when?

Then, data was collected through photographed and audio-recorded group interviews, mediated by the experiential technique "Train Travel", in which participants divided into subgroups of 11 people should answer six questions in a rotation scheme, circulating in the meeting room clockwise, in order to contribute to the answers to all questions [2]. Each question represented a season of the trip and was organized by alphabetical order: a) "What is a group to you?"; b) "What is not a group to you?"; c) "What fears and challenges do I have in running groups?", d) "What drives me to group practice and what helps?", e) "What do I need to be, know, or have to run groups?"; f) "What restricts and hinders group practice?". After visiting all the stations, at the end of the answer circuit, each subgroup returned to the question where the "train trip" started, organized, and presented the collective production.

The "Cycle of Experiential Learning"[10,12] was employed to systematize and process the group experience. It is a sequence of collective discussions organized into four interdependent stages: 1) carrying out the activity; 2) describing and critically analyzing the results and the process experienced; 3) conceptualizing and theoretically recognizing learning; and 4) connecting with reality[10,17].

This study's data were analyzed according to the thematic modality content analysis method described by Minayo[18] to discover the core meanings in the data corpus and identify the significant categories that responded to the targeted analytical objectives. The technological support of the webQda software[19] was adopted in data sorting, pre-analysis, material exploration, agglutination and categorization, processing of results, and data interpretation[20] to ensure rigor and systematization in the qualitative data analysis.

Results and discussion

Three analysis blocks emerged with specific thematic categories for each of the investigated factors' axes through data inductive reading, as can be seen in Charts 1 and 2.

Driving factors

The most relevant category in the whole axis of driving factors is the group of participants' aspects. It is the category of "positive experience of group livingness". The workers report that for the participants, the group is a space for coexistence, exchange, belonging, respect, acceptance, self-recognition, solidarity, and cohesion, as evidenced by the fragments of the statements referenced below:

A positive point is the adult user's interest in attending and participating in the groups. (Reference from 1 – Participant 13)

The exchange of experiences, greater adherence of users, an opportunity for everyone to participate and talk about positive and negative issues that happen to them. (Reference from 2 - Participant 12)

The feeling of belonging. They recognize each other. S, so it makes the group practice a lot easier. (Reference 2 - Participant 20)

The group is a therapeutic strategy with proven effectiveness. Interactions among group members and between group members and the coordinator can function as powerful mechanisms for change in the group. Such mechanisms are known as therapeutic factors or curative factors and are "the active ingredient" of the group[21,22]. They are related to the climate of trust and security in the interactions, the effects of symptoms and personality styles of the participants on the group, the effects of the members' progress and relapses on others, the group mechanisms of change such as acceptance and inclusion, and the learning resulting from the experience of healthier interpersonal relationships. Such aspects can strongly influence the participation of each in the group context[22].

The therapeutic group is a collective psychosocial intervention that can bring benefits to the participants and professionals involved, contributing to lower demands for individualized care and establishing an environment where the attentive professional identifies specific demands and performs significant actions to promote health and prevention of diseases, which is not always possible in individual care due to the time available[23].

Chart 1. Driving factors of group practice in specialized mental health services, Goiás, Brazil, 2020.

Name	Refs	Sources	Description
Service-related aspects			
Appropriate structural conditions	8	4	Structural conditions suitable for group practice, available material, appropriate space for the demand, and the group service modality
Teamwork	2	2	Bonding and positive interaction between workers
Assured access	9	7	Time flexibility, establishing groups in the territory, meeting the high demand of users, and streamlining the professional team
User-related aspects			
Perceived outcomes	5	4	Users' perceived therapeutic benefits achieved through the group
Positive group experience	23	10	Liking the group as a space for socialization, exchange, belonging, respect, acceptance, universality, and cohesion
Professional-related aspects			
Knowledge of the subject	3	3	Knowledge about group dynamics (what is a group, group process, and group reading)
Coordination skills	16	5	Have group coordination skills.
Group attitude	17	5	Attitudinal aspects for cooperative and democratic relationships

Source: Authors.

Two categories appear more prominently in the block of aspects related to professionals: the worker's "group attitude" (17 occurrences) and the "skill for group coordination" (18 occurrences), and the category of "knowledge of the field of group dynamics" (3 occurrences). Group attitude concerns the professionals' characteristics that make them available for collective and democratic coexistence, such as tolerance, respect, empathy, understanding, leadership. Participant 17's fragment exemplifies this:

The CAPS professional must be welcoming, receptive, empathetic, sensitive, internally available, loving, willing, desiring, wanting, happy, flexible, a leader, and assertive to coordinate the group. (Reference 8)

The category of "skill for group coordination" includes the ability to resolve conflicts, knowing how to communicate, the ability to make the group work in a united and cohesive way, mastering the issues of group planning, and good performance in conducting techniques and group experiences.

The literature points out that a professional is competent for a particular activity when he has a set of knowledge, skills, and attitudes about the action he performs[24]. Therefore, the competence to coordinate therapeutic groups is an attribute that integrates theory, practice, attitudinal elements, and personal values[25]. Noteworthy is the overvaluation of research participants for the components of skill and attitude of group practice, while the little recognition that theoretical and conceptual mastery of group dynamics can enhance care actions through groups.

In the block of service-related driving factors, the most relevant categories were "adequate structural conditions" and "guarantee of access", as exemplified by the responses of the study participants when faced with the question about what facilitates the practice with groups:

Enable several different groups with different professionals and themes. (Reference 2 - Participant 4)

Organization of the environment for group work, physical space suitable for demand, and financial and material resources. (Reference 4 - Participant 11)

As the demand at the unit is high, the groups provide care for everyone, and groups are a way of streamlining the number of available professionals. (Reference 2 - Participant 3)

The structure refers to the spatiotemporal setting of the group. This dimension includes

Chart 2. Restrictive factors of group practice in specialized mental health services, Goiás, Brazil, 2020.

Category	Refs	Sources	Description
User-related aspects			
Ethical challenges	10	6	Ethical dilemmas and conflicts among group members, stigma, and prejudice
"Basic disease" limitations	12	3	Difficulties that the user brings due to mental illness
Interaction difficulties	11	3	Behavioral limitations to establish interpersonal relationships in the group
Resistance	25	11	Unavailability and poor adherence of users to this type of service, difficulty in speaking in the group, absences, and delays
Service-related aspects			
Access barriers	8	4	Service opening hours limiting the presence of users
Misalignment to the psychosocial model	18	3	Aspects of the unit's work process that mark a functioning distant from the psychosocial model. Closest to the outpatient
Team disarticulation	5	2	Difficulties in the work process of the multidisciplinary team
Structural limitations	36	7	Lack of material resources, inadequate physical space for the care demand and type, and lack of professionals
Weak employment relationships	5	2	Professionals are hired for a fixed period, without rights or professional security
Professional-related aspects			
Individualistic attitudes	11	4	Attitudinal aspects that make socialization, cooperation, and group life unfeasible
Conceptual ignorance	20	5	Lack of theoretical knowledge about group dynamics (what is a group, group process, and group reading)
Coordination deadlock	18	2	Difficulty in handling challenging situations in the group
Group planning difficulties	14	3	Difficulties in establishing criteria for creating groups, choosing the activities to be done, and confusion in defining the group's goals
Fears and anxieties of professionals	13	2	Anxieties, anxieties, dilemmas, and fears of professionals in coordinating groups

Source: Authors.

the selection criteria for members, the number of participants, the frequency and duration of the meetings, and the material and human resources required for the group's existence[11,26,27]. The literature reveals that the adequate physical structure of institutions and the availability of material resources are driving factors for group practice[13].

Restrictive factors

Thinking about and taking care of the concrete structural aspects of the group is fundamental for the success of the activities. However, what can be seen is that adequate rooms and available material resources do not by themselves guarantee a good result of group practice. Notwithstanding this, contradictorily, the lack of an adequate structure limits and sometimes prevents groups from occurring in an appropriate and therapeutically efficient way, and proof of this is that the category "structural limitations" is indicated by the participants as the one that most restricts (36 occurrences) group practice in the services, as can be seen in the statements below:

Our space is a negative point, as there are only two rooms for the groups. For approximately two

months, a room is off-limits due to cracks and leaks in the ceiling, with the risk of collapse. (Reference 3 – Participant 16).

The lack of financial investment, human and material resources for handicrafts, teaching materials, and computer resources. (Reference 1 – Participant 2).

A comparative global analysis shows a more significant number and variety of restrictive factors than drivers and that professionals believe that the restrictive factors with the most significant repercussion are those in the aspects related to services and then to users. In general, while diagnosing, people neglect or minimize their role in the analyzed context and often point to "others" and the "environment" as restrictive forces[28].

Concerning user-related aspects, the most relevant category was "resistance", which indicates the unavailability or poor adherence of users to this type of service, the fear of talking and exposure in a group, and frequent absences and delays.

The difficulty for some users to join the group, and because of that, they keep walking, talking, and disturbing the group's progress. (Reference 2 - Participant 19)

Users demand individual care. When it is talked about in a therapeutic group, patient resistance is observed. (Reference 4 - Participant 9)

Users insist on understanding the need for group activity. (Reference 8 - Participant 15)

Some users do not adhere to the techniques. They do not remain until the end of the meeting and the group. (Reference - Participant 19)

According to the general population's understanding, the biomedical care model based on an individual visit to a specialist doctor is still the dominant care perspective, which shows that the Psychiatric Reform still needs to be consolidated both for society and managers of public health policies[29].

Therapeutic adherence and resistance in the context of group care offers are complex phenomena, crossed by multiple factors, among which we highlight the quality of the activities performed, the professional-user bond, the relationship between the users of the group and in the group, the issue of cognitive limitations arising from mental disorders. These aspects can hinder the feeling of inclusion and belonging to the group context.

Resistance is a natural process that arises whenever an organism (a person or a group) is faced with an object possibly threatening its internal balance and control[30]. We cannot think of a group without resistance, as this content underpins the group therapeutic process. Resistance is a type of contact, so when it occurs in the group or the psychosocial care service, the professional must accept, respect, and carefully observe it to understand its quality. It provides essential information about how users and the group structure their perception of themselves and reality, especially commitment and emotional attachment[31].

Regarding the restrictive factors related to professionals, a deep intertwining between the emerged categories can be observed. By order of event, we have firstly "conceptual ignorance" (20 times) followed by "coordination deadlock" (18 times), "group planning difficulties" (14 times), "fears and anxieties of professionals" (13 times), and finally, the "individualistic attitudes" (11 times) explained in the lines below:

We never stopped thinking about what the group is and what the group is not. We do it, but we never stopped. We never really tried to know what it is. We know that we form a group, but we don't really know what it is. (Reference 1 – Participant 16)

I have doubts about the formation of the group, characteristics, format, how it will develop, this analysis control here will affect the formation of the group, how it will develop, what composition of the participants will be, and whether it will be adhered to or not. (Reference 3 – Participant 16)

What anguishes me most is feeling that I could have done more and better, what to improve, more creativity and enthusiasm on my part, and techniques to work with them comprehensively. (Reference 5 – Participant 16)

In psychosocial care, the demand for group work is essential, given that care is centered on the community and the family, based on the principles of comprehensiveness and interdisciplinarity. Mental health care at the Psychosocial Care Center requires a complex set of knowledge, skills, and attitudes for group management from the worker[32]. Thus, workers who coordinate groups should know the theory that supports the sociocultural, philosophical, psychological, and epistemological aspects of group dynamics. Aligning practice with a theoretical anchorage and openness to collective life can provide "magnifying lenses" to understanding group phenomena, ensuring the coordinator's safety in reading the group's functioning, planning, and management[33].

Unfortunately, in the coordination of groups and therapeutic workshops, it is common for some professionals to overvalue the technique.

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Many people understand that it is only necessary to master some superficial "games", "techniques", and "dynamics", applied in the absence of group movement without theoretical knowledge to coordinate groups. However, this is a troubling mistake that can generate a group action devoid of therapeutic sense and uncommitted to the users' therapeutic goals[2,3,34].

What is a group?

We could apprehend the concept of what the group is and is not per the workers' understanding from the careful analysis of the data.

A group is the union of two or more people with a common goal, and this group may have different opinions, contributions, exchanges, discussions, experiences, expectations, and provocations. It's the multidisciplinary team, patience, and service, and network. It's therapy, meeting, and something that promotes interaction, learning, and change. It is a work tool that seeks to involve people who want to leave their comfort zone and find change. Its objective is personal and collective growth. It is a place for socializing and personal identification. It is the place that allows me to recognize the similarities and respect the differences. The group is a democratic space that promotes autonomy and empowerment of the subject. It is a collective construction. A warm, receptive space for feelings, emotions, growth, and mutual help. It's a space for acceptance and inclusion of the different, learning to get along, an exercise of belonging, recognition, and strengthening of bonds, a boundary-setting space, an evolutionary strategy for preserving the species, and biological necessity. (Reference 1 – Participant 16).

The group is not individualism, selfishness, disunity, inflexibility, disrespect, intolerance, lack of dialogue, interaction, communication, availability, and interest. A group is not a group of people without something, without a common goal, people gathered by obligation or convenience. It's not prejudice, being stuck in the 'little house', and overcrowding (of users). The group is not a space that does not allow freedom of expression, labels and reinforces the pathology, provides individualized care in the group (does not circulate the statement), lectures when there is no active listening and interaction between members. (Reference – Participant 18)

The dialogic principle of complexity says that it is necessary to think about the "thing in itself" and its opposite in order to understand the organizing, productive, and creative processes, and dynamic concepts such as groups, as antagonism brings an inseparable complementarity to the apprehension of reality[34], knowing what the group facilitates and brings professionals closer to group practice. However, despite the indications of how the group should be and function within the concept built by the workers, it is inferred that there is a lack of information on how these elements integrate into the group process.

The descriptions above corroborate the concept that the group consists of a relatively small number of people who interact and establish reciprocal relationships to achieve common goals. The groups are characterized as a totality in continuous movement, in unstable and temporary equilibrium. They are mediators of the uniqueness of subjects in the social environment in which they live[11].

Final considerations

The results achieved in this investigation allowed the understanding of the group concept that supports the practice of the workers surveyed in coordinating therapeutic groups, which enabled the identification of their theoretical conceptions regarding the use of the group as a care technology. However, what is perceived throughout the investigation is that knowing what groups are does not guarantee the existence of theoretical mastery of group dynamics, nor is it sufficient to efficiently coordinate groups toward achieving the full potential of this therapeutic technology.

The study showed that several categories of restrictive aspects cross the practice with therapeutic groups in CAPS. Recognizing and improving such aspects mobilized in workers who participated in this action research an opening to the experience of reflection-action-reflection and the attempt to build new ones and inspiring group practices in mental health services.

Issues related to users such as resistance to the proposal of group care, the fear of revealing oneself in the group context, and inconsistent assiduity and punctuality in meetings emerged as barriers that can be managed by improving workers' skills in the use of group technology. Resistance by users benefiting from group therapies is part of the group therapeutic process and should be seen as content to be unveiled and worked on by the group itself.

The potentiating aspects of group practices in the context of mental health, identified in this investigation, reinforce the therapeutic and cohesive capacity of group technology, with particular emphasis on the elements related to the positive

experiences of the members of the groups, such as emotional and relational aspects facilitated by sharing experiences.

Concerning the professionals, issues related to competence (knowledge, skills, and attitudes) for the use of group technology that enhances group practice emerged. Regarding the driving factors related to the services, the availability of adequate physical structure to support group and group interventions was evidenced as a mechanism to guarantee assistance to all those seeking assistance at the CAPS.

Regarding the limitations of the investigation, it is noteworthy that there were no users and family members among the participants of this study, only members of the multidisciplinary teams and managers of mental health services. Including other actors involved in group care would richly contribute to further discussions, which makes further research meaningful.

Collaborations

FC Nunes prepared the structure and the initial text of the paper and approved the final version. JM Sousa and ES Pinho worked on analyzing and interpreting data and reviewing the paper. CC Caixeta, MA Barbosa, and AP Costa carried out a critical review and approved the final version to be published.

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