03 - 28.3 Group Psychotherapy, Combined Individual

28.3 Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama

28.3 Group Psychotherapy, Combined Individual and Group Psychotherapy, and Psychodrama Group psychotherapy is a modality that employs a professionally trained leader who selects, composes, organizes, and leads a collection of members to work together toward the maximal attainment of the goals for each individual in the group and for the group itself. Certain properties present in groups, such as mutual support, can be harnessed in the service of providing relief from psychological suffering and supply peer support to counter isolation experienced by many who seek psychiatric help. Similarly, homogeneously composed small groups are ideal settings for the dissemination of accurate information about a condition shared by group members. Medical illness, substance abuse, and chronic and persistent severe psychiatric conditions, including schizophrenia and major affective disorders, are cases in point. A widely accepted psychiatric treatment modality, group psychotherapy uses therapeutic forces within the group, constructive interactions among members, and interventions of a trained leader to change the maladaptive behaviors, thoughts, and feelings of emotionally distressed individuals. In an era of increasingly stringent financial constraints, decreasing emphasis on individual psychotherapies, and expanding use of psychopharmacological approaches, more patients have been treated with group psychotherapy than with any other form of verbal therapy. Group therapy is applicable to inpatient and outpatient settings, institutional work, partial hospitalization units, halfway houses, community settings, and

private practice. Group psychotherapy is also widely used by those who are not mental health professionals in the adjuvant treatment of physical disorders. The principles of group psychotherapy have also been applied with success in the fields of business and education in the form of training, sensitivity, and role-playing. Group psychotherapy is a treatment in which carefully selected persons who are emotionally ill meet in a group guided by a trained therapist and help one another effect personality change. By using a variety of technical maneuvers and theoretical constructs, the leader directs group members' interactions to bring about changes. CLASSIFICATION Group therapy at present has many approaches. Some clinicians work within a psychoanalytic frame of reference. Others use therapy techniques, such as transactional group therapy, which was devised by Eric Berne and emphasizes the here-and-now interactions among group members; behavioral group therapy, which relies on conditioning techniques based on learning theory; Gestalt group therapy, which was created from the theories of Frederick Perls, enables patients to abreact and express themselves fully; and client-centered group psychotherapy, which was developed by Carl Rogers and is based on the nonjudgmental expression of feelings among group members. Table 28.3-1 outlines the major group psychotherapy approaches.

Table 28.3-1 Comparison of Types of Group Psychotherapy PATIENT SELECTION To determine a patient's suitability for group psychotherapy, a therapist needs a great deal of information, which is gathered in a screening interview. The psychiatrist should take a psychiatric history and perform a mental status examination to obtain certain dynamic, behavioral, and diagnostic information. Table 28.3-2 outlines the general criteria for the selection of patients for group therapy.

Table 28.3-2 Therapist's Role in Group Therapy Authority Anxiety Those patients whose primary problem is their relationship to authority and who are extremely anxious in the presence of authority figures may do well in group therapy because they are more comfortable in a group and more likely to do better in a group than in a dyadic (one-to-one) setting. Patients with a great deal of authority anxiety may be blocked, anxious, resistant, and unwilling to verbalize thoughts and feelings in an individual setting, generally for fear of the therapist's censure or disapproval. Thus, they may welcome the suggestion of group psychotherapy to avoid the scrutiny of the dyadic situation. Conversely, if a patient reacts negatively to the suggestion of group psychotherapy or openly resists the idea, the therapist should consider the possibility that the patient has high peer anxiety. Peer Anxiety Patients with conditions such as borderline and schizoid personality disorders who have destructive relationships with their peer groups or who have been extremely isolated from peer group contact generally react negatively or anxiously when placed in a group setting. When such patients can work through their anxiety, however, group therapy can be beneficial. Robert entered therapy seeking to understand why he was unable to maintain close or lasting relationships. A handsome and successful businessman, he had made a painful and courageous transition away from self-centered, dysfunctional parents early in his life. Although he made good initial impressions in his jobs, he was always puzzled and disappointed when his superiors gradually lost interest in him and his colleagues avoided him. In one-on-one therapy, he was charming and entertaining, but was easily injured by perceived narcissistic slights and would become angry and attacking. Group psychotherapy was suggested when his transference feelings remained intense and therapy was at a seeming impasse. Initially, Robert charmed the group and strove to be the center of attention. Visibly annoyed whenever he felt the group leader was paying more attention to other members, Robert was especially critical and hostile toward older people in

the group and displayed little empathy for others. After repeated and forceful confrontations from the group about his

antagonistic behavior, he gradually realized that he was repeating childhood patterns in his family of desperately seeking the attention of unloving parents and then entering violent rages when they lost interest. (Courtesy of Normund Wong, M.D.) Diagnosis The diagnosis of patients' disorders is important in determining the best therapeutic approach and in evaluating patients' motivations for treatment, capacities for change, and personality structure strengths and weaknesses. Few contraindications exist to group therapy. Antisocial patients generally do poorly in a heterogeneous group setting because they cannot adhere to group standards; but if the group is composed of other antisocial patients, they may respond better to peers than to perceived authority figures. Depressed patients profit from group therapy after they have established a trusting relationship with the therapist. Patients who are actively suicidal or severely depressed should not be treated solely in a group setting. Patients who are manic are disruptive but, once under pharmacological control, do well in the group setting. Patients who are delusional and who may incorporate the group into their delusional system should be excluded, as should patients who pose a physical threat to other members because of uncontrollable aggressive outbursts. PREPARATION Patients prepared by a therapist for a group experience tend to continue in treatment longer and report less initial anxiety than those who are not prepared. The preparation consists of having a therapist explain the procedure in as much detail as possible and answer the patient's questions before the first session. STRUCTURAL ORGANIZATION Table 28.3-2 summarizes some of the critical tasks that a group therapist must face when organizing a group. Size Group therapy has been successful with as few as 3 members and as many as 15, but most therapists consider 8 to 10 members the optimal size. Interaction may be insufficient with fewer members unless they are especially verbal, and with more than 10 members, the interaction may be too great for the members or the therapist to follow. Frequency and Length of Sessions Most group psychotherapists conduct group sessions once a week. Maintaining continuity in sessions is important. When there are alternate sessions, the group meets

twice a week, once with and once without the therapist. Group sessions generally last anywhere from 1 to 2 hours, but the time limit should be constant. Marathon groups were most popular in the 1970s but are much less common today. In time-extended therapy (marathon group therapy), the group meets continuously for 12 to 72 hours. Enforced interactional proximity and, during the longest time-extended sessions, sleep deprivation break down certain ego defenses, release affective processes, and theoretically promote open communication. Time-extended sessions, however, can be dangerous for patients with weak ego structures, such as persons with schizophrenia or borderline personality disorder. Homogeneous versus Heterogeneous Groups Most therapists believe that groups should be as heterogeneous as possible to ensure maximal interaction. Members with different diagnostic categories and varied behavioral patterns; from all races, social levels, and educational backgrounds; and of varying ages and both sexes should be brought together. Patients between the ages of 20 and 65 years can be included effectively in the same group. Age differences help in developing parent–child and brother–sister models, and patients have the opportunity to relive and rectify interpersonal difficulties that may have appeared insurmountable. Both children and adolescents are best treated in groups comprising mostly persons in their own age groups. Some adolescent patients are capable of assimilating the material of an adult group, regardless of content, but they should not be deprived of a constructive

peer experience that they might otherwise not have. Open versus Closed Groups Closed groups have a set number and composition of patients. If members leave, no new members are accepted. In open groups, membership is more fluid, and new members are taken on whenever old members leave. MECHANISMS Group Formation Each patient approaches group therapy differently and, in this sense, groups are microcosms. Patients use typical adaptive abilities, defense mechanisms, and ways of relating, and when these tactics are ultimately reflected back to them by the group, they learn to be introspective about their personality functioning. A process inherent in group formation requires that patients suspend their previous ways of coping. In entering the group, they allow their executive ego functions—reality testing, adaptation to and mastery of the environment, and perception—to be assumed, to some degree, by the collective assessment provided by the total membership, including the leader. Therapeutic Factors

Table 28.3-3 outlines 20 significant therapeutic factors that account for change in group psychotherapy. Table 28.3-3 Twenty Therapeutic Factors in Group Psychotherapy ROLE OF THE THERAPIST Although opinions differ about how active or passive a group therapist should be, the consensus is that the therapist's role is primarily facilitative. Ideally, the group members themselves are the primary source of cure and change. The climate produced by the therapist's personality is a potent agent of change. The therapist is more than an expert

applying techniques; he or she exerts a personal influence that taps such variables as empathy, warmth, and respect. INPATIENT GROUP PSYCHOTHERAPY Group therapy is an important part of hospitalized patients' therapeutic experiences. Groups can be organized in many ways on a ward. In a community meeting, an entire inpatient unit meets with all the staff members (e.g., psychiatrists, psychologists, and nurses). In team meetings, 15 to 20 patients and staff members meet; a regular or small group comprising eight to ten patients may meet with one or two therapists, as in traditional group therapy. Although the goals of each group vary, they all have common purposes: to increase patients' awareness of themselves through their interactions with the other group members, who provide feedback about their behavior; to provide patients with improved interpersonal and social skills; to help the members adapt to an inpatient setting; and to improve communication between patients and staff. In addition, one type of group meeting is attended only by inpatient hospital staff and is meant to improve communication among the staff members and to provide mutual support and encouragement in their day-to-day work with patients. Community meetings and team meetings are more helpful for dealing with patient treatment problems than they are for providing insight-oriented therapy, which is the province of the small-group therapy meeting. Group Composition Two key factors of inpatient groups common to all short-term therapies are the heterogeneity of the members and the rapid turnover of patients. Outside the hospital, therapists have large caseloads from which to select patients for group therapy. On the ward, therapists have a limited number of patients to choose from and are further restricted to those patients who are both willing to participate and suitable for a smallgroup experience. In certain settings, group participation may be mandatory (e.g., in substance abuse and alcohol dependence units), but mandatory attendance does not usually apply in a general psychiatry unit. In fact, most group experiences are more productive when the patients themselves choose to enter them. More sessions are preferable to fewer. During patients' hospital stays, groups may meet daily to allow interactional continuity and the carryover of themes from one session to the next. A new member of a group can be brought up to date quickly, either by the therapist in an orientation meeting or by one of the members. A newly admitted patient has often

learned many details about the small-group program from another patient before actually attending the first session. The less frequently the group sessions are held, the greater the need for a therapist to structure the group and be active in it. Inpatient versus Outpatient Groups Although the therapeutic factors that account for change in small inpatient groups are

similar to those in the outpatient settings, there are qualitative differences. For example, the relatively high turnover of patients in inpatient groups complicates the process of cohesion. But the fact that all the group members are together in the hospital aids cohesion, as do the therapists' efforts to foster the process. Sharing of information, universalization, and catharsis are the main therapeutic factors at work in inpatient groups. Although insight more likely occurs in outpatient groups because of their longterm nature, some patients can obtain a new understanding of their psychological makeup within the confines of a single group session. A unique quality of inpatient groups is the patients' extragroup contacts, which are extensive because they live together on the same ward. Verbalizing their thoughts and feelings about such contacts in the therapy sessions encourages interpersonal learning. In addition, conflicts between patients or between patients and staff members can be anticipated and resolved. Twelve former psychiatric inpatients who attended the monthly medication clinic would meet for 1 hour before their individual appointments with the psychiatrist to review their current social situation and medications. All had been treated by the same ward doctor and had known one another while on the inpatient service. The psychiatrist who performed the medication reviews also served as the group leader. Periodically, he was assisted by a staff member who was also familiar with the patients. Coffee was available, and the patients often brought pastries from home. The patients socialized with one another during the hour and frequently exchanged helpful ideas and tips about job opportunities. Those without cars shared rides with other members. The group was open ended and well attended. Most of the patients were single and had a long history of psychotic illness. For most, this meeting was their only opportunity to socialize and be among peers. Frequently, on learning that a member had been rehospitalized, many in the group would visit their colleague on the ward. (Courtesy of Normund Wong, M.D.) SELF-HELP GROUPS Self-help groups comprise persons who are trying to cope with a specific problem or life crisis and are usually organized with a particular task in mind. Such groups do not attempt to explore individual psychodynamics in great depth or to change personality functioning significantly, but self-help groups have improved the emotional health and well-being of many persons. A distinguishing characteristic of the self-help groups is their homogeneity. The members have the same disorders and share their experiences—good and bad, successful and unsuccessful—with one another. By so doing, they educate one another, provide mutual support, and alleviate the sense of alienation usually felt by persons drawn to this kind of group. Self-help groups emphasize cohesion, which is exceptionally strong in these groups. Because the group members have similar problems and symptoms, they develop a strong

emotional bond. Each group may have its unique characteristics, to which the members can attribute magical qualities of healing. Examples of self-help groups are Alcoholics Anonymous (AA), Gamblers Anonymous (GA), and Overeaters Anonymous (OA). The self-help group movement is presently in ascendancy. These groups meet their members' needs by providing acceptance, mutual support, and help in overcoming maladaptive patterns of behavior or states of feeling that traditional mental health and medical professionals have not generally dealt with successfully. Self-help groups and therapy groups have begun to converge. Self-help groups have enabled their members to give up patterns of unwanted behavior; therapy groups have helped their members

understand why and how they got to be the way they were or are. COMBINED INDIVIDUAL AND GROUP PSYCHOTHERAPY In combined individual and group psychotherapy, patients see a therapist individually and also take part in group sessions. The therapist for the group and individual sessions is usually the same person. Groups can vary in size from 3 to 15 members, but the most helpful size is 8 to 10. Patients must attend all group sessions. Attendance at individual sessions is also important, and failure to attend either group or individual sessions should be examined as part of the therapeutic process. Combined therapy is a particular treatment modality, not a system by which individual therapy is augmented by an occasional group session or a group therapy in which a participant meets alone with a therapist from time to time. Rather, it is an ongoing plan in which meaningful integration of the group experience with the individual sessions yields reciprocal feedback to help form an integrated therapeutic experience. Although the one-to-one doctor–patient relationship makes a deep examination of the transference reaction possible for some patients, it may not provide other patients with the corrective emotional experiences necessary for therapeutic change. The group gives patients a variety of persons with whom they can have transferential reactions. In the microcosm of the group, patients can relive and work through familial and other important influences. Techniques Differing techniques based on varying theoretical frameworks have been used in the combined therapy format. Some clinicians increase the frequency of individual sessions to encourage the emergence of the transference neurosis. In the behavioral model, individual sessions are scheduled regularly, but they tend to be less frequent than in other approaches. Whether patients use a couch or a chair during individual sessions depends on a therapist's orientation. Techniques such as alternate meetings or "aftersessions" without the therapist present may be used. A combined therapy approach called structured interactional group psychotherapy has a different group member as the focus of each weekly group session who is discussed in depth by the other members.

Results Most workers in the field believe that combined therapy has the advantages of both dyadic and group settings, without sacrificing the qualities of either. Generally, the dropout rate in combined therapy is lower than that in group therapy alone. In many cases, combined therapy appears to bring problems to the surface and to resolve them more quickly than might be possible with either method alone. PSYCHODRAMA Psychodrama is a method of group psychotherapy originated by the Viennese-born psychiatrist Jacob Moreno in which personality makeup, interpersonal relationships, conflicts, and emotional problems are explored by means of special dramatic methods. Therapeutic dramatization of emotional problems includes the protagonist or patient, the person who acts out problems with the help of auxiliary egos, persons who enact varying aspects of the patient, and the director, psychodramatist, or therapist, the person who guides those in the drama toward the acquisition of insight. Roles Director. The director is the leader or therapist and so must be an active participant. He or she has a catalytic function by encouraging the members of the group to be spontaneous. The director must also be available to meet the group's needs without superimposing his or her values. Of all the group psychotherapies, psychodrama requires the most participation from the therapist. Protagonist. The protagonist is the patient in conflict. The patient chooses the situation to portray in the dramatic scene, or the therapist chooses it if the patient so desires. Auxiliary Ego. An auxiliary ego is another group member who represents something or someone in the protagonist's experience. The auxiliary egos help account for the great range of therapeutic effects available in psychodrama. Group. The members of the psychodrama and the audience make up the group. Some are participants, and others are observers, but all benefit from the experience to the extent that they can identify with

the ongoing events. The concept of spontaneity in psychodrama refers to the ability of each member of the group, especially the protagonist, to experience the thoughts and feelings of the moment and to communicate emotion as authentically as possible. Techniques The psychodrama can focus on any special area of functioning (a dream, a family, or a

community situation), a symbolic role, an unconscious attitude, or an imagined future situation. Such symptoms as delusions and hallucinations can also be acted out in the group. Techniques to advance the therapeutic process and to increase productivity and creativity include the soliloquy (a recital of overt and hidden thoughts and feelings), role reversal (the exchange of the patient's role for the role of a significant person), the double (an auxiliary ego acting as the patient), the multiple double (several egos acting as the patient did on varying occasions), and the mirror technique (an ego imitating the patient and speaking for him or her). Other techniques include the use of hypnosis and psychoactive drugs to modify the acting behavior in various ways. ETHICAL AND LEGAL ISSUES Confidentiality Except where disclosure is required by law, the group therapist legally and ethically gives information about the group members to others only after obtaining appropriate patient consent. The therapist is obligated to take appropriate steps to be responsible to society, as well as to patients, when patients pose a danger to themselves or to others. The guidelines for ethics of the American Group Psychotherapy Association state that therapists must obtain specific permission to confer with the referring therapist or with the individual therapist when the patient is in conjoint therapy. Although the group members, as well as the therapist, should protect the identity of the members and maintain confidentiality, the group members are not legally bound to do so. During the preparation of patients for group psychotherapy, therapists should routinely instruct the prospective members to keep all material discussed in the group confidential. Theoretically, in a legal case, one member of a group can be asked to testify against another, but such a situation has not yet occurred. A therapist must exercise clinical judgment and caution in placing a patient in a group if he or she thinks that the burdens of maintaining secrets will be too great for some potential members or if a prospective group patient harbors a secret of such magnitude or notoriety that membership in a group would not be wise. Violence and Aggression Although reports of violence and aggression are rare, the potential exists that a group member may physically attack another patient or a therapist. The attack may occur within the group or outside the group. The likelihood of such an event can be diminished through the careful selection of group members. Patients with a demonstrated history of assaultive behavior and psychotic patients who pose a potential for violence should not be placed in a group. In institutional settings, in which group therapy is commonly practiced, sufficient safeguards must be in place to discourage any physical danger to others—for example, guards or attendants can act as observers. Sexual Behavior

For therapists, sexual intercourse with a patient or a former patient is unethical; in many states, such behavior is considered a criminal act. The issue is complicated in group psychotherapy, however, because members may engage in sexual activities with one another. The issues of pregnancy, rape, and the transmission of acquired immunodeficiency syndrome (AIDS) by group members are open questions. If a patient is injured as a result of sexual activity by group members, the therapist could be held accountable for not preventing such behavior. The therapist should advise prospective group members that each patient is responsible for reporting any sexual contact between members. The therapist cannot anticipate every group sexual encounter or prevent sexual relationships from developing, but he or she is obligated to provide patients with guidelines of acceptable behavior. The therapist should identify sexual, vulnerable, or exploitive

patients in the selection and preparation of patients for the group. Sociopathic patients who sexually exploit others should be informed that such behavior is explicitly not acceptable in the group and that such behavior should be verbalized rather than acted out. The group must be conducted in such a way that the therapist does not encourage or tacitly allow sexual activity. Patients with AIDS are encouraged to reveal that they harbor the virus. To protect members if sexual relationships occur, some therapists do not accept patients with AIDS into a group unless they agree to reveal their condition. In those situations, the therapist discusses the issue of AIDS with the patient and the group into which the patient is to be placed. REFERENCES Billow RM. Bonding in group: The therapist's contribution. Int J Group Psychother. 2003;53:83. Burlingame GM, Fuhriman A, Mosier J. The differential effectiveness of group psychotherapy: A meta-analytic perspective. Group Dynamics. 2003;7:3. Friedman R. Individual or group therapy? Indications for optimal therapy. Group Anal. 2013;46(2):164–170. Higaki Y, Ueda S, Hatton H, Arikawa J, Kawamoto K, Kamo T, Kawasima M. The effects of group psychotherapy in the quality of life of adult patients with atopic dermatitis. J Psychosom Res. 2003;55:162. Ogrodniczuk JS, Piper WE, Joyce AS. Treatment compliance in different types of group psychotherapy: Exploring the effect of age. J Nerv Ment Dis. 2006; 194(4):287–293. Paparella LR. Group psychotherapy and Parkinson's disease: When members and therapist share the diagnosis. Int J Group Psychother. 2004;54(3):401–409. Scheidlinger S. Group psychotherapy and related helping groups today: An overview. Am J Psychother. 2004;58(3):265– 280. Segalla R. Selfish and unselfish behavior: Scene stealing and scene sharing in group psychotherapy. Int J Group Psychother. 2006;56(1):33–46. Spitz H. Group psychotherapy. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:2832. Tyminski R. Long-term group psychotherapy for children with pervasive developmental disorders: Evidence for group development. Int J Group Psychother. 2005;55(2):189–210. van der Spek N, Vos J, van Uden-Kraan CF, Breitbart W, Cuijpers P, Knipscheer-Kuipers K, Willemsen V, Tollenaar RA, van Asperen CJ, Verdonck-de Leeuw IM. Effectiveness and cost-effectiveness of meaning-centered group psychotherapy in cancer survivors: protocol of a randomized controlled trial. BMC Psychiatry. 2014;14:22.

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