Achieving Cohesiveness in Therapy Groups of Chronically Disturbed Patients

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During the past ten years, three factors have led to the treatment of more and more chronically psychotic, schizoid, severe borderline, and otherwise marginally functional people in community settings. These factors are: (a) the increased availability of psychiatric services in the community, (b) vigorous outreach efforts by community mental health workers, and, more recently, (c) deinstitutionalization. Since it is difficult to engage these patients in any effective therapeutic relationship, they are generally "managed," "monitored," or "followed" in one-to-one relationships. A frequent arrangement is 15-minute weekly or bimonthly meetings between therapist and patient. This type of therapy has generally been successful in maintaining the patients' current level of functioning and has frequently prevented many re-hospitalizations. (Hogarty, Goldberg, & the Collaborative Study Group, 1973; MacLeod & Middleman, 1962; Purvis & Miskinims, 1970). There have been few controlled studies comparing the relative efficacy of minimal individual contact with group therapy for aftercare patients (Levine et al., 1970; Shatton et al., 1966). However, several reports indicate that a group treatment approach is beneficial for these patients in terms of social effectiveness (Comstock & Jones, 1975; Masnik, Bucci, Isenberg, & Normand, 1971; O'Brien et al., 1972). Despite the fact that there is considerable agreement as to the beneficial effects of a group therapy approach, the nature and particular dynamics in the formation of these groups have not been discussed.

As the group psychotherapy consultant to several community mental health agencies (neighborhood health centers, mental health clinics, and psychiatric day-hospitals) located in the innercity and

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affiliated with the department of psychiatry in a university medical center, I have supervised the formation of many groups of these chronic patients. In doing so, I have found that the theoretical and practical approach used in the formation of groups of healthier patients is inappropriate and requires modification. This paper is an effort to identify and discuss the stages in the formation of cohesive groups of patients generally considered to be too disturbed or hopeless for any but the most limited psychotherapeutic treatment.

PATIENT POPULATION

Typical group members are patients who are severely schizoid, borderline, or chronically psychotic. The only criterion for exclusion is grossly disruptive behavior such as shouting, screaming, or actively hallucinating. Three illustrative vignettes follow:

> J.O. is a 42-year-old Irish Catholic woman who has been hospitalized several times. She is shy, soft-spoken, withdrawn, and avoids dealing directly with any major emotional issues. In the past she has worked as a cook in rectories and orphanages. In periods of decompensation she has sexual delusions about priests. Currently she lives in a halfway house.

> P.C. is a 32-year-old man with a long history of early deprivation and foster care. Ten years ago he was working as a printer and used drugs quite heavily. About three years ago he was hospitalized after breaking up with a woman. Since then he has been living at home in a passive dependent relationship with his mother and is immobilized by homosexual, suicidal, and homicidal ruminations.

> L.R. is a 30-year old married woman who has one child. Her two older brothers are in prison serving life sentences for having murdered a policeman (this is a source of pride for L.R.'s mother). Her parents were divorced when she was 13 years old. She recalls that during most of her childhood she daydreamed to avoid thinking about the violent and incestuous relationships at home. She describes herself as "stupid" and wonders why she hates herself so much. She was reunited with her father recently when he was hospitalized with terminal cancer. Since that time she has had an overwhelming desire to become pregnant. She handles her frequent anxiety attacks by eating or drinking. She and her husband hate each other but cannot bear to leave each other. She says, "He's my conscience."

STAGES IN THE DEVELOPMENT OF GROUP COHESIVENESS

1. Outreach

Despite the fact that patients may be seen in several individual orientation sessions before the first group meeting, this stage of the group is characterized by irregular attendance. When patients fail to attend they do not inform the therapist of their planned absences. Group sessions are marked by long silences. Members rarely speak to one another but instead request advice from the therapist. During this early stage in group development it is very important for the therapist to be energetic in his outreach efforts both inside and outside the group. Outside the group he must repeatedly encourage members to attend sessions by making telephone calls, sending letters, and even making home visits. During group sessions, the therapist should not hesitate to engage members in one-to-one discussions with him, solicit members' opinions about the topic at hand, and otherwise manage and stimulate interpersonal interaction. I have found that commenting on the here-and-now of the group process—specifically, the difficulty members are having establishing relationships with one another —tends to inhibit rather than to facilitate cohesiveness. Patients who are this emotionally disturbed cannot yet stand the level of intimacy, interaction, and postponement of gratification that these group process comments require. Yalom (1974) also describes this phenomenon of the dissolution of group cohesiveness resulting from the therapist's repeated use of group process comments. The task at this stage of group development is for the therapist and patients to find a way to be comfortable in the room together. If the therapist can restrain his desire for members to have more intimate interactions with one another and allow the group to discuss superficial and emotionally uncharged issues relating to life outside the group, this sense of comfort will begin to develop.

2. Embryonic Cohesiveness

Within about four months, full attendance becomes the rule rather than the exception. Interactions become more meaningful; more eye contact develops between members; topics become more personal

and less chatty, members make comments that follow from or are related to other members' comments, and the leader becomes much less the focus of attention.

3. Fragmentation of Embryonic Cohesiveness

The stage of embryonic cohesiveness is very short lived, lasting perhaps only two or three sessions. During the next four to six weeks attendance falters. In contrast to earlier behavior, however, members now generally inform the therapist of their planned absences. The group composition varies markedly, with only occasional sessions in which the same members are present. More outreach is required at this stage but rarely in the form of home visits.

During this stage the therapist frequently feels angry, defeated, and hopeless and fears that he has made some serious errors. Despite the disappointing turn of events, it is crucial that the therapist recognize this as a necessary stage in the group's development. He should resist the temptation to change his style of leadership.

4. Formation of a Cohesive Group

If the therapist has been diligent in his renewed outreach efforts and has refrained from commenting on members' fears of developing relationships with one another, attendance will begin to rise and, within about four weeks, full attendance will be achieved once again. There is a marked absence of discussion about the recent disruptions. The therapist's efforts to encourage members to discuss the absences as a manifestation of some group dynamic are ignored or met with silence and bewilderment. As the group reforms, silences diminish, member-to-member contacts increase, and efforts are made to find topics that all members can comfortably discuss. The content remains superficial, however, and generally related to matters outside the group. When personal problems are mentioned, they are dealt with quickly and concretely. Rarely are the psychological aspects of personal problems or their possible solutions explored. The following is an example of this stage of the group process:

> In one session, a member complained that her stomachaches had been getting worse and wondered what she should do about them. Another member said that she had heard that romaine lettuce soup was helpful for stomachaches and asked the first member whether she had ever tried this remedy. The conversation quickly turned to comparison of various soup recipes and then to what people did and didn't enjoy eating. All members participated in this animated discussion and there was virtually no silence during the entire session.

As more and more sessions like this one take place, participation by all members increases, complete attendance becomes a regular weekly occurrence, and group cohesiveness begins to solidify. However, the group seems to be developing into a social club rather than a therapy group. Topics discussed relate to neighborhood gossip and local current events rather than to difficulties members are experiencing in their personal lives. At this point the therapist may begin to feel isolated, excluded, and discouraged. The interactions seem to proceed without his facilitating comments and the topics seem nontherapeutic. In an effort to help the group move in a more therapeutic direction he may be tempted to make more group process comments or to connect manifest and latent content. If he does this he will once again interfere with the developing cohesiveness. His disappointment in the "gossipy" social club nature of the group may prevent him from appreciating the therapeutic effects the group has already had on its members: they have begun to look better, dress better, and have increased their social contacts outside the group.

> D.P. and M.P. are two middle-aged sisters who have been locked into a symbiotic relationship with one another for many years. D.P. was hospitalized in 1971 with the diagnosis of chronic paranoid schizophrenia and involutional depression. Since her discharge, she has been "well controlled" by bimonthly injections of fluphenazine (Prolixin) and brief visits with her nurse-therapist. In group sessions, D.P. smokes continuously and has a noticeable hand tremor. She has great difficulty tolerating any group tension and deals with this by leaving to go to the bathroom or interrupting the flow of conversation to complain about her "jumpy stomach." Her sister M.P. participates actively in the group. She expresses her feelings easily, gives support and advice to other members, and has an appealing sense of humor. Despite M.P.'s complaints of continual stomach pains she has been reluctant to consult a doctor for fear of what he might find. Her greatest source of self-esteem is her ability to care for her sister. Both sisters blame each other for their lack of friends and social contacts.

D.P. and M.P. have attended the same group for the past 8 months. During this time, the cohesiveness of their group has steadily

increased. All members attend regularly and participate; however, members have rarely discussed any significant personal issues. On occasion, one of the sisters has mentioned the tension in their relationship, but neither the therapist nor any other member has chosen to pursue it. In the past month or so, M.P. made an appointment for a medical examination and both sisters have begun to attend church together.

THE COHESIVE GROUP

As group cohesiveness becomes more firmly established, the topics and interaction become much more personal and less superficial. The "social club" atmosphere seems to dissolve:

> L.S. is a 62-year-old schizoid woman who works as a domestic. For the past 10 years she has been separated from her alcoholic husband. She lives alone in a housing project and rarely sees any of her five children or many grandchildren. Several years ago one of her daughters had a psychotic episode and was hospitalized for several months in a state of catatonia. After monopolizing group sessions for 7 months with endless complaints about life in her housing project, L.S. has begun to talk about her loneliness and yearnings to be close to her children. She mentioned "silent" telephone calls that she receives at night and feels that these are her oldest son's only way of communicating with her. As L.S. has begun to discuss her relationship with her children, her participation in the group has become less monopolistic and other members have begun to respond to her in a more supportive and empathic way.

The evolution of a more intimate, less superficial group process seems to take place naturally and spontaneously rather than as a result of the therapist's deliberate efforts to guide the group in this direction. In fact, the more the therapist expects, hopes for, and attaches great value to a more personal and intimate group process, the less likely it is to develop. As the atmosphere in the cohesive group becomes more intimate and the interaction more empathic, the therapist becomes excited, hopeful, and gratified. The long hard months of work are finally paying off and the therapist may feel like celebrating. As a result of these feelings of elation, the therapist may not appreciate that a more empathic, personally meaningful group process results in more anxiety for group members. Anxiety seems to be at its highest levels

when members talk about some personal issue that is deeply meaningful to them. It appears that group members can tolerate only a small amount of genuine personal contact. In this stage of group formation it is important that the therapist not convey to the group his satisfaction and excitement in the deepening nature of the group process. He must respect members' needs to distance themselves repeatedly from each other and the group as a whole when the anxiety resulting from genuine human contact gets too high. If the therapist is not sensitive to this dynamic, the cohesiveness that has taken so long to develop may fragment once again.

SUMMARY AND DISCUSSION

The evidence for the effectiveness of using a group therapy approach in the treatment of chronically disturbed patients has been presented. The stages and tasks of the therapist in the formation of a cohesive group of these patients have been identified and discussed. These stages can be distinguished from the more familiar patterns found in groups of healthier outpatients in the following ways:

1. The development of cohesiveness requires 6 to 8 months rather than 2 to 3 months.
2. The therapist must be open to active outreach efforts inside and outside the group.
3. The therapist must recognize that commenting on the group process and here-and-now of the group interaction will inhibit rather than facilitate the development of cohesiveness.
4. The therapist must restrain himself from conveying satisfaction and excitement as the group becomes more cohesive and the process more personal and meaningful.
5. As a result of the months of patient-therapist interaction, the superficial nature of the topics discussed, the minimal member-to-member empathic responses, and the need for the therapist's restraint in expressing satisfaction as the group develops, the therapist may develop countertransference responces of rage, boredom, and disappointment; he must be aware of and deal with these.

At the present time there are several of these cohesive groups in each of the community agencies to which I am a consultant. These group sessions have become a central weekly event in the lives of the

group members and have helped them to develop a less isolated, more meaningful existence. In addition, there have been signs of other small therapeutic advances: group members have begun to look and dress better and have begun to make more social contacts among themselves and with others outside the group.

As more therapists discover the usefulness of a group approach in the treatment of chronically disturbed patients, more group therapy is attempted with this patient population. Frequently, however, these groups falter and dissolve because therapists lack an appreciation of the unique dynamics of group formation with these patients. This paper is an attempt to correct this situation and present useful guidelines for therapists who wish to engage in this helpful and satisfying endeavor.

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