

**CURRENT PRACTICES IN
GENERAL HOSPITAL GROUP PSYCHOTHERAPY**

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(ABSTRACT)

The purpose of this survey study was to evaluate the current practice of inpatient group therapy in general hospital psychiatric units in a southeastern state and to determine whether there was a need for a more systematic method of designing, implementing, and evaluating general hospital group therapy. A second major purpose was to test a model to determine if it could be used to evaluate current practices of general hospital psychiatric group therapy on a more global basis.

The history of group therapy and current nationwide statistical data relating to general hospital psychiatric units were summarized. A survey which addressed unit operations, unit staffing patterns, types of patients, and general practices regarding psychiatric unit group therapy was administered to 35 general hospital psychiatric unit administrators in a southeastern state. A standard interview protocol was developed and administered on-site to six group therapy practitioners. These interviews gathered information relative to specific unit group therapy practices, evaluated whether Group Pentagon components were utilized in group therapy practices, and identified factors influencing unit group therapy practice.

An analysis of the available literature indicated there was little information relative to the practice of group therapy on general hospital psychiatric units. The literature analysis also revealed no consistent model or procedures for the design, implementation, and evaluation of group therapy in general hospital psychiatric units. The survey and interviews demonstrated that group therapy programs appeared fragmented, varied across units, and did not appear to be designed, implemented, or evaluated in a consistent manner. During the interviews, the practitioners described the lack of many of the conditions necessary for the provision of effective group therapy on their general hospital psychiatric units.

The literature review analysis, survey, and interviews indicated the components of the Group Pentagon were not utilized in general hospital group therapy programs. The Group Pentagon provided a useful model for evaluating overall group therapy programs, as well as reviewing specific group therapy procedures. Finally, this research established a protocol for evaluating general hospital and potentially other group therapy practices.

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CHAPTER ONE

Introduction

Background and Theoretical Framework

For many years inpatient psychiatric treatment has been utilized to treat psychiatric disorders for large numbers of people. Since the Middle Ages significant improvements have been made in methods of treatment for people with psychiatric disorders, while the past 25 years reflect dramatic changes in these treatment areas (Zimpfer, 1987). These changes in methods and modalities can be tracked through the years and involve improvements in many treatment areas including medications, individual therapy, and group therapy (Kibel, 1992).

One of the primary and most common modalities of treatment for these patients is group therapy. Parloff and Dies (1977) note the emerging role of group therapy in inpatient treatment. More recently, Yalom (1983) and Brabender and Fallon (1993) cite the importance of group therapy in the treatment of mental or emotional disorders. Spitz (1996) notes that a group experience of some kind is a regular component of the overall treatment plan for almost every psychiatric patient whose condition is serious enough to warrant hospitalization. There are very practical reasons for this development. Some studies show group therapy to be as effective as individual therapy for many patients (MacKenzie, 1990). Group therapy provides the basis for treating as many people as possible, in the shortest time possible, with the fewest therapists (Zimpfer, 1984, and Spitz, 1996). Indeed, from a perspective of resource utilization as well as clinical effectiveness, there is no other treatment modality available that utilizes the fewest resources and involves the most patients (Yalom, 1975).

Yet, with all the research and writing devoted to specific group therapies and techniques on inpatient psychiatric units, there has been little research documenting what these programs across the country are doing in their group therapy programs. There is even less information available on general hospital psychiatric unit group therapy programs. Studies conducted have used small samples. Even Yalom's (1983) notable work is based on a sample of 25 inpatient psychiatric units, many with similar characteristics such as size, location, and kinds of patients. Surprisingly, there is limited information about the practices and procedures of these kinds of programs across the country (Kapur, R., Ramage, J., and Walker, K., 1986).

Among general hospital psychiatric units there does not appear to be a consistent method of designing, implementing, and assessing inpatient group therapy programs (Brabender, 1993; and Farley, 1996). Furthermore, these group therapy programs do not specify current behavior, problems, goals of treatment, methods to be utilized, or evaluate the effectiveness of the treatment (Brabender, 1993, and Farley, 1996). Thus, in terms of characteristics of these units, methods or procedures of the groups on these units, and techniques for designing, implementing, and evaluating the group programs on these units, this researcher found there is a notable absence of information on group work.

Although there has been some research in the past 25 years relative to designing groups for inpatient psychiatric units (Brabender and Fallon, 1993), treatment programs do not appear to be using any systematic, individualized procedures for providing group therapy for patients

(Beeber, 1991). As Winegar, Bistline, and Sheridan (1992) assert, group therapy will, for the foreseeable future, be a central facet of inpatient treatment. Consequently, there appears to be a need for the development of a process for using specific goal related group methodologies with outcome measures to determine the effectiveness of the intervention. Yalom (1983, 1995) espouses the clinical relevancy of a pragmatic, easy to learn model to provide an experience useful to patients. The apparent lack of a generally used model suggests the desirability of a model practitioners could use to assess the effectiveness of their work. The Group Pentagon (Hutchins, 1993) has been developed for such a purpose.

The Group Pentagon is a model for designing effective counseling and therapeutic groups for problematic conditions that would merit group treatment (Hutchins, 1993); however, to date the model has not been tested in a general hospital psychiatric unit setting. This model was designed to assist group counselors in constructing specific group and individual goals and methodologies for patients and is capable of addressing a wide range of problems. The literature on group therapy is clear about the importance of setting goals to implement and sustain behavioral change (Corey and Corey, 1992). The Group Pentagon is easily adapted to the development of specific group and individual goals to increase the probability of success in therapy. It provides a specific process for selecting patients and tracking patients' movement through group therapy.

The Group Pentagon model is composed of five key elements including (a) current behavior of potential or actual members, (b) expectations or goals of the group and the patient, (c) methods of treatment or procedures which will be used in the group, (d) consequences/risks or impact of these procedures, and (e) an evaluation of the effectiveness of the interventions. These elements are all interrelated, each affecting and being affected by each of the other elements. Since the group process is very dynamic, constantly adapting to changing patient problems and goals, the group therapist always knows the appropriateness of a given behavior and can quickly consider the impact of any event going on in the group.

In addition to providing a systematic, individualized process for administering group therapy to patients, the Group Pentagon can be used to review existing practices, organizing the group planning and implementation process under the five dimensions and thereby producing a clear and concise evaluation of those programs. In summary, the model provides a pragmatic tool for the clinician to design, implement, and measure the benefits of a common treatment modality.

The Research Problem

The problem for this study is that there was little, if any, research on the current practices of adult group therapy programs in general hospital psychiatric units. An analysis of the literature indicated that since Yalom's study (1983), there had not been a systematic update of group therapy practices on inpatient psychiatric units across the country. Indeed, an analysis of the literature indicated there appeared to have never been a comprehensive review of general hospital group therapy programs. A pilot study (Farley, 1996) of general hospital group therapy programs indicated that such programs appear to plan group treatment in the absence of individual considerations and without having specific patient related goals.

Pilot Study: To determine if a systematic process for administering group therapy to inpatients is currently being used in treatment, a pilot study (Farley, 1996) was conducted using

inpatient psychiatric units in Virginia, West Virginia, Pennsylvania, and California. Seven units were selected for their geographical differences and variance in size. The Program Director with each facility was interviewed by the researcher via telephone. Survey questions, developed by the researcher, focused on descriptions of the units (e.g., locked versus unlocked, number of beds) and methods for designing and conducting group programs and group therapy. Table 1.1 reviews the seven units and separates the group treatment strategies into the five Group Pentagon components that are used to evaluate the group process.

Results of this pilot study indicated:

- Current Behavior: Patients were placed in group therapies irrespective of individual behavior or goals.
- Goals: Most treatment programs did not establish group therapy goals with or for patients in a particular group.
- Methods: Techniques or methods of therapy were almost always described as eclectic, were based on individual therapist expertise which varied from unit to unit and was associated with education and training, and were not specifically based on patient problems or goals.
- Risks: No programs assisted the patient or their guardian in identifying or understanding risks or consequences associated with group therapy.
- Evaluation: No programs provided any type of specific outcome measures to determine effectiveness of the group process or patient goal attainment.

Discussion with Program Directors at these hospitals indicated that placement of patients in groups seems to be determined by a “shotgun” method based on expertise of and convenience to therapists. Differences among these programs reflected a variety of methods for assigning patients to groups. Such methodologies for assigning patients to groups were based on DSM-IV diagnosis, subjective assessment of level of functioning, and whether or not a patient was actively psychotic. One psychiatric unit simply assigned patients to attend all groups regardless of behavior, diagnosis, symptoms, or goals. As an analogy, this approach applied to pharmacology would result in a pharmacist giving a patient with an infection a handful of different antibiotics because they were all used to treat infections, but without specifying which was to be used for what symptom.

In summary, a systematic, individualized method of assigning patients to groups, determining their treatment in these groups, and evaluating the outcomes of their treatment was not utilized. Such programs appeared to plan group therapies without individual and specific patient related goals. There were few positive similarities among these programs, indicating the absence of a process to effectively plan, design, and implement systematic group therapy programs. Thus, the problem for this study was that there was:

- (A) little, if any, research on the current practices of adult group therapy programs in general hospital psychiatric units; and
- (B) a strong suggestion that such programs administered group therapy programs in highly idiosyncratic ways without systematic plans.

TABLE 1.1

Therapeutic Practices and Group Pentagon Categories in
Seven General Hospital Psychiatric Unit Group Therapy Programs

PROGRAM	CURRENT BEHAVIOR	GOALS	METHODS	RISKS	EVALUATION
# 1 24 Beds	Psychotic vs. non psychotic determines group attendance	None established	Eclectic, Primarily Didactic	Not discussed with patients	None
#2 20 Beds	DSM IV-R diagnosis determines placement in groups	Each group has a goal established by the staff	Eclectic	Not discussed with patients	None
#3 20 Beds	High functioning vs. low functioning subjective judgment of staff	None established	<u>Process</u> Didactic	Not discussed with patients	None
#4 20 Beds	DSM IV-R diagnosis determines group placement	None established	“Flexible”	Not discussed with patients	None
#5 26 Beds	Acuity (severity) of dysfunction determines group placement	None established.	Cognitive <u>Behavioral</u> Psycho-Educational	Not discussed with patients	None
#6 14 Beds	Severity of dysfunction determines group placement	Established by group Leader	Eclectic	Not discussed with patients	None
#7 14 Beds	Any psychiatric diagnosis All patients attend groups	None established	Eclectic	Not discussed with patients	None

Purpose

The purpose of this study was to evaluate the current practice of inpatient group therapy in general hospital psychiatric units in a southeastern state and to determine whether there was a need for a more systematic method of designing, implementing, and evaluating general hospital group therapy. A second major purpose was to test a model to determine if it could be used to evaluate current practices of general hospital psychiatric unit group therapy on a more global basis.

To accomplish the purposes of this study, the researcher:

- (a) Reviewed and synthesized the extant literature of the historical development of inpatient group therapy;
- (b) Compiled a summary of available statistical data relevant to specific general hospital psychiatric units;
- (c) Identified specific current practices in general hospital psychiatric unit group therapy;
- (d) Evaluated whether the components of the Group Pentagon are currently facets of general hospital psychiatric unit group therapy; and
- (e) Interviewed selected general hospital group psychotherapy practitioners to identify their perceptions of desirable components of effective general hospital group therapy.

Research Questions and Methodology

This study evaluated the current practices of general hospital psychiatric unit group therapy programs in a southeastern state. This survey involved general hospital, adult, psychiatric treatment units and practitioners utilizing group therapy as a regular modality of treatment. This study addressed five research questions in the manner described below:

1. What is the developmental history of inpatient group therapy to date?
This research question was addressed through a summarization of the available literature and cited in Chapter 2.
2. What are the available statistical data relevant to general hospital psychiatric units utilizing group therapy as a customary modality of treatment?
This research question was addressed through information obtained from:
 - (1) The National Center for Mental Health Services; and
 - (2) Results from the General Hospital Psychiatric Unit Survey (Appendix A).
3. What are the current group therapy practices in general hospital psychiatric units?
This research question was answered from:
 - a) an analysis of the available literature;
 - b) results of the General Hospital Psychiatric Unit Survey; and
 - c) results of on-site interviews using the Group Therapy Practitioner Structured Interviews (Appendix B).
4. To what extent are the components of the Group Pentagon utilized in general hospital group therapy?
This research question was addressed in two ways:
 - (1) Data from the literature was assessed and summarized in Chapter 2; and
 - (2) Results from the General Hospital Psychiatric Unit Survey and on-site interviews using the Group Therapy Practitioner Structured Interviews.

5. What are desirable components of group therapy as identified by practitioners of general hospital group therapy?

This research question was addressed through on-site interviews with a subsample of 6 practitioners from the units. The Group Therapy Practitioner interviews assimilated the practitioners' opinions in a structured format that was completed during these on-site interviews.

The General Hospital Psychiatric Unit Survey was addressed to the Program Director on each unit. This individual typically was the person responsible for the overall administrative and clinical functions of the unit. The Group Therapy Practitioner Interviews were administered on-site, following a standard interview protocol, and were specifically directed to group therapy practitioners who participated in the design and delivery of group therapies.

Assumptions

This research on general hospital group therapy relied on three assumptions:

1. The literature review and common practice suggested that group therapy was an integral component of treatment for psychiatric patients.
2. The Group Pentagon was an appropriate model to evaluate current inpatient group practices.
3. A systematic, individualized method of designing, implementing and measuring the outcomes of specific group therapies and group programs has the potential for more effective patient treatment in the future.

Delimitations

This study did not evaluate all aspects of group therapy and treatment. Specifically, the research was delimited to:

1. General hospital psychiatric units in a southeastern state providing group therapy services to patients eighteen and over as identified by the National Center for Mental Health Services, and
2. Six selected practitioners for an in-depth, on-site survey.

Limitations

1. The small sample size of the Group Therapy Practitioner Interviews limited generalization of the results to all general hospital psychiatric units.
2. The response rate from the General Hospital Psychiatric Unit Survey limited generalization to all general hospital psychiatric units.
3. The definition and method of provision of group therapies on general hospital psychiatric units varied somewhat from one setting to another.

Operational Definitions

For the purposes of this study, operational definitions include inpatient group therapy, Group Pentagon, current behavior, patient group goals, group goals, methodologies, group

consequences, evaluation of groups, general hospital psychiatric unit, and group therapy practitioner.

Inpatient Group Therapy: A specialized treatment modality characterized by a small number of participants (usually 8-15), led by a mental health professional, and utilizing specific dynamics including cohesion, confrontation, education, catharsis, and group pressure. A variety of theoretical orientations may be used, usually determined by the leader. The group may meet four to five times per week and is time limited, meaning the patients' number of attended sessions is influenced by how long the patient is hospitalized. The focus of the group may be psychoeducational, remedial, preventive, or task directed. The inpatient group therapy may be characterized by a diverse range of diagnoses, ages, and symptoms and functional impairments. Patient attendance may be voluntary or involuntary.

Group Pentagon: A method for designing, implementing and evaluating effective counseling and therapeutic groups developed by Hutchins (1993). The Group Pentagon has five key elements: current behavior, goals, methods, consequences or risks, and evaluation. Each element relates to each of the others resulting in a highly adaptive process for continually assessing a patient's progress and modifying treatment goals and procedures.

Current Behavior: Current behavior is one of the key elements in the Group Pentagon. Typically, current behavior involves patient self described problems and psychiatric symptoms. Current behavior is the target of the intervention and treatment. It may be described by answering the questions:

- (1) What is the problem that needs to be solved?
- (2) What are the person's thoughts, feelings, and actions in this situation?

Patient Goal: The Patient Goal concept is one of the two facets of the "Goal" element of the Group Pentagon. It is the therapist's and patient's defined solution for the problem or current behavior. The patient group goal is defined with each patient for each group. Patient group goals are defined by answering the questions:

- (1) What goals will solve the problem?
- (2) What are the patient's expectations regarding the group?
- (3) How do I want my thoughts, feelings, or actions to be different following the group?

Group Goal: Group Goal is the second facet of the "Goal" element of the Group Pentagon. The group goal is defined by the group members and the group leader, collectively. This is addressed by answering the questions:

- (1) What do the leader and members want to happen in this group?
- (2) What is the overall purpose of the group?

Methodology: The Methodology concept is the third key element of the Group Pentagon. This element relates to the therapeutic procedures utilized in each group. In the Group Pentagon all procedures are specifically designed to result in changed behavior for each group member. Methodologies are described by answering the questions:

- (1) What group procedures will lead to achievement of specific goals?
- (2) What techniques or interventions are most likely to successfully aid in resolving the problem and attaining the goal?

Consequences: Consequences is the fourth key element of the Group Pentagon. This element is best defined by answering the questions:

- (1) What are the positive and negative impacts of the methods or techniques on each group member?
- (2) How will certain methods affect members both in and outside the group?
- (3) Do potential advantages outweigh the risks?
- (4) Have these risks been discussed with the patient and the group?

Evaluation: Evaluation is the fifth key element of the Group Pentagon. Evaluation relates to individual member changes as well as the group process itself. Evaluation is part of and focused on each element in the Group Pentagon. This element is best defined by answering the following questions:

- (1) Individual change---(a) What changes in patients' thoughts, feelings, and actions have resulted?
 - (b) How are these changes assessed and measured?
- (2) Group process ----- (a) What methods, techniques, and strategies used in the group were associated with change in patient behavior?
 - (b) What methods, techniques, and strategies were used without success?
 - (c) What role did group leadership play in the process?
 - (d) What are implications of group methods for similar groups in the future?

General Hospital Psychiatric Unit: A section of a general, regional, or community hospital devoted to the provision of twenty-four hour inpatient psychiatric treatment. The hospital operates under private, non-profit, state or local government auspices. It provides inpatient medical and surgical services as well as psychiatric services in a separate psychiatric inpatient and/or outpatient and/or partial hospitalization service with assigned staff and space. The inpatient treatment unit may vary in size, legal restrictiveness, or theoretical philosophy of treatment. For the purposes of this study, the inpatient treatment unit serves individuals eighteen years of age and over. All patients admitted have a DSM-IV diagnosis and all units offer group therapy as a typical modality of treatment. The inpatient unit will be licensed as a psychiatric treatment unit (Manderscheid and Sonnenschein, 1994). Locked and open beds refer to the number of beds behind locked doors or the number of beds on unlocked (open) units.

Group Therapy Practitioner: A designated individual on each inpatient psychiatric unit who is responsible, individually or as part of a treatment team, for designing and implementing group therapies. The Group Therapy Practitioner will be licensed or under supervision for licensure in an appropriate profession.

Need for the Study

In conducting a literature review, no systematic update of current trends and practices of inpatient group therapy across all settings since the early 1980's (Yalom, 1983) was found, even in light of significant research in group therapy techniques. There was little, if any, information on group therapy practices in general hospital psychiatric units. Consequently, a comprehensive understanding of the current nature of inpatient group therapy was at best fragmented and based on relatively small samples or anecdotal experience. Additionally, no author had written about what the practitioners of general hospital psychiatric group therapy would see as necessary, desirable, and practical in establishing effective inpatient group therapy programs. No author had applied or written about components of the Group Pentagon with general hospital group therapy programs.

There are dramatic changes taking place in contemporary health care resulting in significant instability in the field. The forms and mechanisms through which behavioral health care services are provided are under attack and will evolve as the forces that affect these forms and mechanisms evolve. Essential issues of cost containment, time restriction, evaluation of the efficacy and outcome of different therapeutic interventions, consumer satisfaction, and financing of health care services are being addressed on every significant level in the field of mental health (Spitz, 1996). A major goal is to provide competent care to large groups of people in short time frames at minimal cost. Group psychotherapy has emerged as a promising modality for addressing these treatment issues. Indeed, the current projected annual charges for general hospital group therapy approach \$348,000,000 (Manderscheid and Sonnenschein, 1994). Group psychotherapy appears to be already firmly entrenched in the treatment regimens for these units.

The current instability in the health care system demands treatment that is relatively brief, highly symptom and goal focused, and clearly defined and documentable relative to treatment outcome and efficacy (Feldman & Fitzpatrick, 1992; Goodman, Brown, & Deitz, 1992). The importance and relevance of group therapy programs addressing and resolving these treatment issues seems crucial if inpatient group psychotherapy is to survive and grow.

The creation of a method to systematically plan, assign, implement, and evaluate the outcomes of group therapy would assist in addressing the above treatment issues. Table 1.2 illustrates the potential benefits of the Group Pentagon, a method for designing inpatient group therapy programs. As described below, effectiveness and efficiency of treatment are enhanced across four areas involving patients, third party carriers and managed care companies, mental health practitioners, and facilities and institutions.

Almost all patients experience some type of symptomatic change while in the hospital. An effective method of designing and implementing group therapy would include the capability of adapting to changing patient problems and goals. Because such a method of designing group therapies addresses behavior and symptoms for every group, the patient's treatment plan constantly changes to deal with new problems and symptoms, thereby resulting in more effective treatment. Potentially, more effective treatment should lead to longer periods of stability, less frequent admissions, and an improved quality of life. Furthermore, patients' therapeutic response would be faster as current problems are constantly being addressed. As a result, the patient would be discharged from the hospital sooner and would experience a more prompt return to

TABLE 1.2

Projected Benefits of the Group Pentagon
as Applied to General Hospital Psychiatric Units

PATIENT	INSURANCE COMPANIES, MANAGED CARE COMPANIES, HEALTH MANAGEMENT ORGANIZATIONS	COUNSELORS, SOCIAL WORKERS, THERAPISTS	FACILITIES, INSTITUTIONS
<p>Faster therapeutic response</p> <p>System adapts to changing patient needs</p> <p>Discharged from hospital sooner</p> <p>Faster return to pre-morbid functioning</p> <p>Less expense due to shorter hospital stay</p> <p>Less frequent admissions, stays stable longer resulting in improved quality of life.</p>	<p>Able to obtain specific group therapy outcome measures, thereby ensuring effectiveness of treatment</p> <p>Decision making regarding authorization of continued treatment is improved</p> <p>Costs are minimized due to improved treatment resulting in shorter length of stays</p>	<p>Can validate patient's involvement in group therapy</p> <p>More confidence in treatment techniques</p> <p>Availability of improved treatment measures</p> <p>Enhanced image of counseling and group therapy as accountability improves.</p>	<p>Reputation improved as a Quality Care Provider</p> <p>Patients return for treatment due to providers positive response</p> <p>Revenues improved as market share is maintained.</p>

premorbid functioning. Less cost to the patient is an important byproduct of more effective treatment and improved stability.

Less cost is also of great interest to insurance companies, managed care companies, and other health care management organizations. The monitoring of treatment and outcome is central to all payers for services as psychiatric hospitalization is the most costly form of psychiatric treatment. There is an enormous desire to ensure that the process of mental health treatment is efficient and documentable. More effective treatment would reduce not only level and intensity of treatment but also length of stay, thereby reducing costs of treatment. Additionally, most inpatient programs do not provide specific outcome measures. An ability to obtain such specific outcome measures would assist these gatekeepers in authorizing initial referrals of patients to programs as well as authorizing continued treatment. With this information available, gatekeepers could more specifically track treatment and treatment effectiveness, thereby substantiating why a patient's placement in a group would be helpful to that patient. Specifically, goals, methodologies, and expected outcomes will have to be delineated. This already occurs with the use of medications and individual counseling. Group therapy will be next.

Group therapists would not only gain a useful, structured tool for treating patients, they would also improve confidence in their methods as they observe and are able to specifically document therapeutic improvements in their patients. The assignment of a patient to a particular group therapy would be validated as a result of relating group methodologies to a patient's problems and goals. Equally important, improved methods of treatment enhance a positive overall image of counseling and group therapy culminating in increased counselor self confidence as well as increased public confidence in the profession.

Finally, facilities and institutions would gain improved reputations as quality care providers which in turn helps to ensure that patients return to that facility for treatment, thereby improving revenues. Referral sources would refer patients to those programs with a history of treatment effectiveness and cost minimization. Patients would want to return to that facility for treatment due to previous positive treatment response. The net result is that both patients and referral sources would be more apt to return to that facility for treatment, thereby aiding the facility in maintaining its market share of business and remaining competitive in the field.

Numerous authors including Toseland and Siporin (1986), Winegar, Bistline, and Sheridan (1992), and Brabender and Fallon (1993), note that in years to come there will be changes in federal legislation and increased scrutiny from insurance and managed care companies resulting in the need for greater accountability from providers in the treatment of their patients. Parloff and Dies (1977) discuss the forces requiring clinicians to provide crisper and more credible evidence of their efforts with clearly defined patient problems and goals. To address this necessity for greater accountability, the need has emerged to develop a system to ensure the most effective, practical, and least expensive way to provide treatment for patients with cognitive, emotional, or behavioral disorders.

As the health care climate across the country has been changing and continues to change into the future, it is without doubt that a greater focus will be ensuring that dollars spent can be justified (Smith, 1991, and Beck, 1994). "Bang for the buck" will become a bottom line (Parloff and Dies, 1977). As Toseland and Siporin (1986) indicate, the issue of efficiency deserves much more attention. Hamilton, Travis, Richmond, Hanson, Swanson, and Stafford (1993) cite the

increasing importance of the monitoring and evaluation of group psychotherapy. The present study was designed to be a move in this direction through evaluation of current practices and identifying concepts of effective general hospital, adult group therapy. This identification of factors for effective general hospital group therapy can, in turn, lead to further exploration and development of a more effective, efficacious, and practical system for providing this treatment modality.

CHAPTER TWO

Literature Review

Introduction

This chapter presents an analysis of current literature related to this research. The reviews and summaries are limited to that research relevant to the history and practice of inpatient group therapy in the United States. Inpatient group therapy is group therapy practiced within parameters that are different from other types of group therapy such as outpatient group therapy or partial hospitalization group therapy. Yet, inpatient group therapy has developed parallel to “general” group therapy and has been highly influenced by research and practices within this broad, overall area (Yalom, 1983; and Erickson, R., (1984).

Although inpatient groups have been formally utilized since the early 1900’s, the practice was based on concepts and approaches developed for long term outpatient groups (Brabender, 1993). Increasingly, practitioners have recognized that inpatient group therapy needs goals and methods of interventions tailored to its unique features and demands. The utilization of group therapy within inpatient programs has grown consistent with the rapid growth of inpatient psychiatric treatment (Witkin, Atay, Sonnenschein, and Manderscheid, 1995). Consequently, inpatient group therapy has emerged as one of the dominant areas of general group therapy necessitating its own domain of research and development.

The history and development of inpatient group therapy as a subset of hospital treatment will be reviewed. Descriptions of general hospital psychiatric units and current practices in these hospitals will be summarized. Finally, research involving general hospital group therapy from 1983-1997 will be summarized utilizing the Group Pentagon components (Hutchins, 1993). This research will be categorized by:

- 1) group therapy models; and
- 2) specific group therapy techniques.

Cited in the literature, group therapy models encompass theory as well as general procedures for conducting group therapy. Group therapy techniques involve the specific methods or procedures being investigated in a study noted in the literature involving general hospital psychiatric group therapy.

History of Inpatient Group Therapy

That we are emerging from the “dark ages” of treatment for emotional disturbance and mental illness is well documented (Erickson, R. 1984). Treatment for people suffering from these illnesses has progressed tremendously in the past 200 years. Inpatient group therapy has also progressed concurrent with advances in all aspects of hospital psychiatric treatment. Edward Lazell (1921), credited with founding inpatient group therapy, developed a didactic approach characteristic of the primarily educative nature of early inpatient group therapy. L. Cody Marsh (1931), ten years later, supplemented the lecture groups with a discussion format which he believed created a positive emotional environment and encouraged mutual patient support. This didactic approach remained popular until World War II.

Just prior to World War II, Louis Wender (1936) introduced experiential elements into the group therapy process. By being the first to apply psychoanalytic concepts to the group process, he expanded the context and scope of inpatient group therapy, helping to legitimize it with the professional community. Psychoanalytic techniques helped shed light on the dynamics of behavior, lower resistance to treatment, and facilitate partial reorganization of the personality (Kibel, 1989). At that point group therapy moved a step closer to alignment with individual therapy, thus gaining validation and credibility with practitioners and researchers.

The use of group therapy in military hospitals during World War II resulted in a heightened focus on and demand for improved techniques. The therapeutic community movement, begun in England, revolutionized the way care was delivered in inpatient psychiatric settings (Main, 1946). It was the development of this treatment environment concept that led to the discovery of such modern day group dynamics as the here-and-now, belongingness, and universality. These group dynamics became the basis for the later development of many theories, types, and techniques of group therapy such as encounter groups, Gestalt groups, and T-groups.

Additionally, the understanding of the potential interaction between the therapeutic group and the therapeutic community led to significant changes in the way inpatient groups are conducted (Foulkes, 1948). For example, inpatient groups were now seen as a medium for patients gaining insight and learning new behaviors within an environment similar to that of everyday life. Progress made within the therapeutic group and community was highly generalizable to everyday life. Heretofore, inpatient group therapy was viewed by practitioners as a sterile microcosm suitable for stabilization only and not as a medium parallel to the patient's everyday world (Kibel, 1989).

During the postwar period, inpatient group work began to flourish. Probably the most significant activity during this time was the work of Powdermaker and Frank (1953). Their theories emphasized the importance of group cohesiveness, the need for role models in the group for behavior modification, and the use of group interactions to assist the patient in gaining a more accurate reflection of self in relation to others. Also, at about the same time, Standish and Semad (1951) stressed facilitating group interaction, recognition and acceptance of patients' underlying emotions, and tolerance for patient symptoms and behaviors. Postwar emphasis on patient relatedness, understanding the meaning of a patient's behaviors, and an atmosphere of acceptance within the group still influences modern day approaches to inpatient groups.

Through the mid-1960's, enthusiasm for inpatient group therapy waned (Frank, 1963). The still strong influence of the psychoanalytic based group process seemed to produce dynamics such as anxiety that impeded rather than promoted patient improvement. Part of the problem was that inpatient groups continued to be molded after outpatient treatments. Differences in the conditions of treatment, such as less time to work with a patient, rapid patient turnover within a group, heterogeneous populations, and questionable motivation for treatment for some inpatients, create unique challenges for the inpatient therapist that are less disruptive for the outpatient therapist (Marcovitz and Smith, 1986). Additionally, the many confounding variables created by the milieu in which the group resides may result in ambiguity and confusion for a patient (Klein, 1977).

Through the late 1960's and early 1970's, interest in inpatient group therapy waned. The advent of neuroleptic medication, anxiolytics, and antidepressant medications had a tremendous

impact on hospital psychiatry (Kibel, 1992). Many patients who had seemed unreachable through verbal therapies became responsive and improved dramatically. Biological treatments became the standard and a “medical model” of treatment came into power (Herz, 1979). This medical model emphasized physician dominance and medications and diminished individual, group, and other dynamic psychotherapies. Only after years of experience has it become apparent that pharmacological agents only affect acute symptoms and a combination of treatment modalities including medications and verbal therapies provide the best long term prognosis (Oldham and Russakoff, 1987).

In the mid to late 1970’s, inpatient group practitioners turned more to interpersonal approaches, particularly those put forth by Yalom (1970). These were structured methods utilizing the “here-and-now” and eschewed milieu, genetic, life stresses, or analytic issues. Over the past 15 years research and practice has been generally pragmatic in nature and relatively non-psychodynamic. Treatment goals, improving social skills, encouraging reality based behavior, and modifying maladaptive symptoms have been the focus (Kibel, 1992). A variety of cognitive, affective, behavioral, and combinations of these have been created and utilized in a multitude of inpatient treatment settings.

Two factors have led to the current day status of inpatient group therapy. One factor was the realization that earlier approaches were not as effective as touted or hoped. A second factor was the realization that changes in the parameters of psychiatric hospital care, including decreased length of stay, required changes in the manner in which group therapy was provided (Kiesler and Simpkins, 1991). Particularly, since 1990, the provision of inpatient care, including group therapy, has been highly influenced by the appearance of managed care and government activity in reimbursement. The long term impact of these new influences remains unknown.

General Hospital Psychiatric Units

It has been noted in the literature (Kapur et al., 1986) that information related to all psychiatric units is sparse. There is even less information on general hospital psychiatric units. The Center for Mental Health Services, under the auspices of the United States Department of Health and Human Services, has compiled statistical data on mental health services and treatment through 1990 and appears to be the singular source for information relating specifically to general hospital psychiatric units.

Kibel (1992) asserted considerable change has taken place in inpatient mental health treatment through the years. During the 20 year period 1970-1990, considerable change has occurred in the number, capacity, structure, and operation of organizations providing mental health services in the United States. A summary of these changes (Redick, Witkin, Atay, and Manderscheid, 1994) for organizations and general hospital psychiatric units reveals that mental health organizations and the overall number of treatment settings have increased while total inpatient psychiatric beds have decreased. General hospital psychiatric treatment units, characterized by fewer beds than other treatment settings, have emerged as the leading inpatient psychiatric treatment setting. Specifically changes are as follows:

- Total number of mental health organizations in the United States increased from 3,005 to 5,284;
- The number of organizations with inpatient settings doubled from 1,734 to 3,430;

- The number of overall psychiatric beds decreased in this time period 524,878 to 272,293 but the number of general hospital psychiatric unit beds increased from 22,394 to 53,479;
- General hospital psychiatric units increased from 664 to 1,571;
- Staffing in all inpatient units increased from 30,982 to 80,625.

By 1983, general hospital psychiatric units had the highest number of patients who received care among all inpatient psychiatric settings, were third in total patient days, and sixth in average length of stay (Table 2.1). By 1990, 41% of all patients receiving inpatient treatment were treated in general hospital psychiatric units (Table 2.2) and Medicare and Medicaid contributed 25% each of general hospital psychiatric unit revenues while client fees accounted for 33% of revenues. Total revenues collected for inpatient mental health settings were 27.8 billion, up 4.5 billion from two years earlier.

Related to total number of general hospital psychiatric units, Redick et al., (1990) report that after increasing in number from 1,351 (1986) to 1,484 (1988) to 1,674 (1990) the total number of general hospital psychiatric units decreased to 1,580 by 1995 (Witkin, Atay, Sonnerschein, and Manderscheid, 1995). The number of units per state varies from three in Nevada and South Dakota to 109 in California with a mean of 30.9 per state (Table 2.3).

Available statistics on general hospital psychiatric units yield no information on locked versus open units, voluntary or involuntary patients, age ranges of patients, providers of group therapy, training of providers, number of patients per group, group therapies per week, or other relevant data regarding psychiatric unit operation or group therapy.

Current General Hospital Psychiatric Group Therapy Practices

Yalom (1983) provided the first notable description of group therapy practices on inpatient psychiatric units. His descriptions were based, though, on a review of 25 units across private psychiatric hospital, university hospital, and general hospital units. Consequently, the observations, while appearing representative, may not be generalizable to all general hospital psychiatric units due to the relatively small number of units reviewed. Nevertheless, his summaries have been accepted as a solid baseline and foundation for inpatient group therapy practice since 1983.

Since 1983 there has been little research regarding a summary of inpatient group therapy practices, much less research regarding group therapy practices in specific treatment settings such as on general hospital psychiatric units. Psychiatric units in 1986 (Kapur, Ramage, and Walker, 1986) were described as typically having 15-35 patients whose hospital stay ranged from one to three weeks. The range of diagnoses or symptomology was broad and included a wide variety of patients. The staff comprised several different professions including nursing, psychiatry, psychology, social work, and occupational therapy. Types of treatment and types of groups varied greatly from unit to unit.

From a comprehensive perspective there were few, if any, summaries of any type of inpatient group therapy after 1986 until 1993 when Brabender (1993) noted that inpatient groups are typically diagnostically heterogeneous but there was a trend toward diagnostically homogeneous groups. She indicated group experience had become short-term, sometimes for only

Table 2.1

Person's Receiving Inpatient Care, Total Patient Days, and Average Patient Days, 1990

Setting	Persons per Year	Total Patient Days	Daily Length of Stay
General Hospital Psychiatric Units	609,000	11,816,000	19
State Mental Hospitals	351,000	40,763,000	116
Alcohol/Drug Treatment Units	195,000	20,548,000	105
Private Psychiatric Hospitals	140,000	4,622,000	33
Veterans Administration Psychiatric Units	138,000	7,425,000	54
Community Mental Health Centers	130,000	6,233,000	48
Total	1,563,000	91,407,000	

Table 2.2

Distribution of Persons Treated in Inpatient Settings, 1990

Settings	Number of Patients	Percent
General Hospital Psychiatric Units	696,000	41
State Hospitals	566,000	32
Private Psychiatric Hospitals	174,000	10
Alcohol/Drug Units	116,000	7
Veterans Administration Psychiatric Units	114,000	7
Community Mental Health Centers	68,000	3
Total	1,734,000	100

Table 2.3

General Hospital Psychiatric Units by State

State	Number	State	Number
Alabama	27	Missouri	49
Alaska	5	Montana	5
Arizona	14	Nebraska	10
Arkansas	14	Nevada	3
California	109	New Hampshire	12
Colorado	19	New Jersey	51
Connecticut	27	New Mexico	7
Delaware	6	New York	103
District of Columbia	8	North Carolina	42
Florida	55	North Dakota	7
Georgia	34	Ohio	81
Hawaii	8	Oklahoma	22
Idaho	4	Oregon	17
Illinois	86	Pennsylvania	102
Indiana	42	Rhode Island	7
Iowa	32	South Carolina	14
Kansas	26	South Dakota	3
Kentucky	27	Tennessee	44
Louisiana	30	Texas	75
Maine	9	Utah	15
Maryland	27	Vermont	5
Massachusetts	61	Virginia	38
Michigan	70	Washington	23
Minnesota	36	West Virginia	11
Mississippi	10	Wisconsin	44
		Wyoming	4

Total = 1,580

one session. So as to maximize patient exposure to group therapy, groups were open ended and patients were required to attend. There were, though, criteria that varied across units that excluded some patients, such as those with organic impairment or those dangerous to other group members. A challenge was to establish goals that could be attained in single group sessions. There were a variety of models of group therapy in use including educational, problem solving, social skills, and cognitive behavioral groups.

Brabender also reported groups were composed of seven to nine members and lasted from 45-75 minutes. Groups met on the unit for a total of five times per week. The group leader was highly active and was capable of performing a variety of tasks and therapeutic techniques. Brabender further noted there were few outcome studies in the literature to test the efficacy of current models and theories of group therapy being used on inpatient units.

Kibel (1993) reported group therapy practices varied from one psychiatric unit to another depending on patient population, length of stay and rate of patient turnover, staffing patterns, availability of therapists to lead groups, and logistics. All patients were encouraged to attend group therapy on the units but patient safety was generally the primary issue related to all patients attending groups. Patients were assigned to groups based on level of functioning, although there was usually no formal process for evaluating patient level of functioning. Five to twelve patients would attend groups for a period of 45-75 minutes with the typical group lasting one hour. Groups were generally conducted four times per week.

The effective leader was described as active, moderately directive, accepting, non-critical, and supportive. Goals for treatment and methods used in groups were quite varied across the units. Kibel also noted that to date, there was a general lack of evidence relative to the effectiveness of one group therapy approach over another.

In summary, little research and writing from 1983-1997 was found describing current practices on inpatient units in all settings, much less general hospital psychiatric units. The information available is fragmented in that few variables are reviewed and those variables reviewed differ from author to author. Finally, to say there have been significant and voluminous changes in psychiatric healthcare in the past five years is without question. Descriptions of the pragmatic impact of these changes on group therapy practices in general hospital psychiatric units has not been noted in the literature.

General Hospital Group Therapy Literature Review Using the Group Pentagon Components

Literature previously discussed in this Chapter has indicated group therapy was an important component of inpatient psychiatric treatment. Because the general hospital psychiatric unit setting has its own unique characteristics (such as being a part of a multi-service medical/surgical hospital rather than an independent, free standing psychiatric hospital), this literature search was limited to group therapy research in the United States pertaining to adult, psychiatric units in general hospitals. An analysis of the literature revealed numerous studies on inpatient group therapy have been conducted since Yalom's first book on inpatient group therapy (Yalom, 1983). The vast majority of these studies do not directly relate to the general hospital psychiatric unit. Most group therapy research since 1983 has involved or been targeted

toward outpatient group therapy, inpatient substance abuse group therapy, non-adult patient populations, or settings other than general hospital psychiatric units (i.e., Veterans Hospitals or private psychiatric hospitals). Consequently, there is limited research in the literature pertaining to group therapy on adult, general hospital psychiatric units in the United States.

In Chapter One, the Group Pentagon (Hutchins, 1993) was suggested as a model for designing, implementing, and evaluating group therapy as well as a model for reviewing existing group therapy practices. The available literature pertaining to group therapy practices on adult, general hospital psychiatric units in the United States was reviewed and analyzed using the five elements of Group Pentagon. This literature was categorized by:

- 1) models of group therapy relevant to general hospital psychiatric unit group therapy; and
- 2) studies conducted on or specifically pertaining to group therapy techniques on general hospital psychiatric units.

Although two of the above models of group therapy were proposed before 1983 they were included in this review because they are still currently used on some units.

Models of Group Therapy Table 2.4 reviews models of group therapy described in the literature that specifically pertained to general hospital psychiatric units. A model of group therapy includes theory and general procedures used in group therapy practices. Using the Group Pentagon as a framework for analysis, deficiencies in the models are delineated. This review of the models indicated:

- Current Behavior: For the purposes of this review, this component described how patients were assigned to group therapies. Three of the models indicated all patients attend all groups and delineated no exclusionary criteria. Patient placement in groups frequently was influenced by some type of assessment of level of functioning, as noted in five of the thirteen models, but the criteria for this assessment is not described and appears subjective. One group therapy model is designed specifically for Schizophrenic and Borderline Personality Disorder patients but noted all patients may attend. This model was the only one specifying any patient clinical criteria being used for assignment of patients to groups. One group therapy model recommended any voluntary patients appropriate for group therapy should attend but did not define “appropriate.” Similarly, two other models assigned patients to groups on the basis of “fit” of interpersonal styles and similarity of cognitive development but did not clearly define interpersonal styles or similarity of cognitive development. Finally, one model indicated all patients attend all groups except threatening, suicidal, psychotic, or dementia patients. Conclusion: Collectively, the models suggested patients were assigned to group therapies irrespective of individual patient behavior or goals and when some type of selection criteria was used, it was vague or not defined.
- Goals: The group therapy models described in the literature were evaluated using this Group Pentagon component relative to patient goals for each group and group goals for each group. Eight of the thirteen models did not establish or describe any patient goals per group. Three models noted patient goals for each group were established in some prearranged manner (i.e., at the beginning of the week). Two of the thirteen models reported patients were

TABLE 2.4

Review of General Hospital Group Therapy Models
Using the Group Pentagon Components

MODEL	CURRENT BEHAVIOR	GOALS	METHODS	RISKS	EVALUATION
Solution Oriented Model Coe & Zimpfer, 1996	All voluntary patients, appropriate for and committed to treatment, attend all groups	The patient makes goals at various times during treatment but no goals set for each group No group goals for each group	Eclectic, primarily cognitive and behavioral, while progressing through four stages of treatment Techniques applied to all patients	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
Interpersonal Model Yalom, 1995 and 1983	Any patient functionally able to attend Assignment to groups may involve assessment of level of functioning	Patient assisted in setting goals for each group Group goals for each group revolve around agenda setting	Eclectic, determined by group leader Emphasis on here-and-now	Not discussed with patient	Subjective and objective measures of patient progress Group process- <u>No</u> Overall program- <u>No</u>

Cohn Model Cohn, 1994	All patients attend all groups Some assignment based on levels of functioning	No patient goals for each group No group goals for each group	Eclectic techniques Identify, discuss, and process milieu and system issues	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
Kibel Model Kibel, 1993	All patients attend all groups except those with threatening or suicidal behavior, the floridly psychotic, or Dementia patients	No patient goals for each group No group goals for each group	Eclectic, process oriented. Support and exploration of milieu interactions emphasized	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
Cognitive Behavioral Model Beck, 1991	All patients attend all groups	No patient goals per group No group goals for each group	Cognitive and behavioral techniques used for all patients	Not discussed with patient	Patient progress per group measured with objective outcome measures Group process-- <u>No</u> Overall program-- <u>No</u>

<p>Developmental Model Ashback & Schmerer, 1987</p>	<p>Assignment to groups based on therapist determination of patient interpersonal styles</p>	<p>No patient goals per group No group goals for each group</p>	<p>Analytical techniques for all patients Group proceeds through stages of growth</p>	<p>Not discussed with patient</p>	<p>Patient progress-- <u>No</u> Group process-- <u>No</u> Overall program-- <u>No</u></p>
<p>Maves & Schultz Model Maves & Schultz, 1985</p>	<p>All patients attend all groups Assignment to groups may involve assessment of level of functioning</p>	<p>Pre-established patient goals not based on specific patient symptoms No group goals for each group</p>	<p>Eclectic techniques to all patients to decrease anxiety and reassure</p>	<p>Not discussed with patient</p>	<p>Patient progress-- <u>No</u> Group process-- <u>No</u> Overall program-- <u>No</u></p>
<p>Brabender Model Brabender, 1985</p>	<p>All patients attend all groups but must be able to separate fantasy from reality</p>	<p>No patient goals for each group No group goals for each group</p>	<p>Eclectic techniques and based on therapist determined phases of patient improvement</p>	<p>Not discussed with patient</p>	<p>Patient progress-- <u>No</u> Group process-- <u>No</u> Overall program-- <u>No</u></p>

Object Relations Model Alonso & Rutan, 1984	All Schizophrenic and Borderline Personality Disorder patients but all patients can attend	No patient goals per group No group goals for each group	Use of psychoanalytical techniques focusing on the here-and-now	Not discussed with patient	Patient progress-- <u>No</u> Group process-- <u>No</u> Overall program-- <u>No</u>
Educational Model Maxmen, 1984	Assignment to groups based on level of functioning	No patient goals per group No group goals for each group	Psychoeducational, teaching methods Emphasizes here-and-now Methods apply to all patients in group and are predetermined by the therapist	Not discussed with patient	Patient progress-- <u>No</u> Group process-- <u>No</u> Overall program-- <u>No</u>
Hannah Model Hannah, 1984	All patients attend all groups	No patient goals for each group No group goals for each group	Empathy, confrontation, and support for all patients	Not discussed with patient	Patient progress-- <u>No</u> Group Process-- <u>No</u> Overall program-- <u>No</u>

<p>Social Skills Training Model Flowers, 1979</p>	<p>All patients attend all groups</p>	<p>Patient goals per group set with therapist</p> <p>General group goals preset by therapist</p>	<p>Behavioral techniques used for all patients</p>	<p>Not discussed with patient</p>	<p>Patient progress measured with objective outcome measures</p> <p>Group process-- <u>No</u></p> <p>Overall program-- <u>No</u></p>
<p>Problem Solving Model Spivack et al, 1976</p>	<p>All voluntary patients similar in cognitive development</p>	<p>Patient group goals involves learning specific problem solving steps</p> <p>No group goals for each group</p>	<p>Problem solving methods taught to all patients</p>	<p>Not discussed with patient</p>	<p>Patient progress-- <u>No</u></p> <p>Group process-- <u>No</u></p> <p>Overall program-- <u>No</u></p>

- assisted in setting specific goals for each group. Eleven of the thirteen group therapy models did not establish or describe group goals being set for each group. One model described prearranged (at the beginning of the week) group goals for each group while one model indicated group goals for each group were determined by a setting of an agenda for each group and was the only model to establish group goals for each group at the time of each group. Conclusion: This review indicated treatment goals for each patient for each group and group goals for each group were either absent or not described for the majority of inpatient group therapy models.
- Methods This component of the Group Pentagon was used to evaluate how procedures to be used in each group were determined. The methods recommended by each group therapy model were based on the theoretical underpinnings of that model. For example, the Problem Solving model taught problem solving methods during each group. For each model, the methods were applied to all patients in the group and did not appear to have any direct connection to an individual patient's behavior, problems, or treatment goals. Procedures used in each group were therefore usually determined in advance and directly related to the group therapist's theoretical preferences. Six of the models noted the use of eclectic techniques that were predetermined (usually at the beginning of the week) and based on the therapist's familiarity with the theory. Conclusion: Clearly, methods or procedures to be used in each group do not appear to be directly related or connected to a patient's behavior, symptoms, or treatment goals.
- Risks: This component of the Group Pentagon was used to evaluate how models identified and explained to patients the risks or consequences of participation in group therapies. Conclusion: None of the models identified or explained to patients the risks or consequences of participation in group therapy.
- Evaluation: The group therapy models were reviewed using this Group Pentagon component relative to the evaluation of patient progress per group, the evaluation of the group process, and the evaluation of the overall group therapy program. Ten of the thirteen models of inpatient group therapy described no methods for the evaluation of patient progress per group. Three of the models did provide for outcome measures or patient progress per group. None of the thirteen models provided for evaluation of the group process and none of the thirteen models provided for evaluation of the overall group therapy program. Conclusion: Evaluation of patient progress, groups, or group therapy programs is minimal, if at all.

Group Therapy Practices Table 2.5 reviews studies conducted on or specifically pertaining to group therapy methods or techniques used on general hospital psychiatric units. The Group Pentagon was again used as a framework for the analysis of the studies. The review of the studies indicated:

- Current Behavior: For the purposes of this review, this Group Pentagon component evaluated if and how patient assignment to group therapies was a factor in this study. Four of the seven studies indicated all patients attended all groups. One study utilized patients

TABLE 2.5

Review of General Hospital Group Therapy Technique Studies, 1983-1997,
Using the Group Pentagon Components

STUDY	CURRENT BEHAVIOR	GOALS	METHODS	RISKS	EVALUATION
Winer & Ornstein, 1994	All patients attend all groups	No patient goals for each group No group goals	Psychoanalytical techniques applied to all patients	Not discussed with patient	None
Pam & Kemker, 1993	All patients attend all groups	No patient goals for each group No group goals	Based on general, person centered techniques - applied to all patients	Not discussed with patient	None
Brand & Clingepeel, 1992	All depressed patients aged 60 and over	No patient goals for each group No group goals	Behavioral techniques for all patients	Not discussed with patient	Specific, objective outcome measures for each group Group process-- No Overall program--No
Sautter & Heaney, 1991	All patients attend all groups	No patient goals for each group No group goals	Problem solving techniques taught and processed for all patients	Not discussed with patient	Patient self evaluates problem solving efforts at end of week Patient per group-- No Group process-- No Overall program-- No

Kahn et al, 1986	Assignment to groups based on Treatment Team judgment of level of functioning	No patient goals for each group No group goals	Psychoanalytical techniques for higher functioning Structured activities for lower functioning	Not discussed with patient	Objective measures for patient per group Group process-- No Overall program-- No
Russakof & Oldham, 1984	All patients attend all groups	No patient per group goals No group goals	Object relations and insight oriented techniques for all patients	Not discussed with patient	None
Lieb & Thompson, 1984	DSM diagnosed Anorexia Nervosa patients	No patient per group goals No group goals	Process and person centered techniques for all patients	Not discussed with patient	Patient self evaluation per group Group process-- No Overall program--No

assigned to groups based on a treatment team's judgment of level of functioning (this judgment was undefined). Only two studies delineated specific symptoms or diagnoses:

- 1) depressed patients aged 60 and over; and
- 2) DSM III diagnosed Anorexia Nervosa patients.

Conclusion: Out of seven studies, five did not address specific patient symptoms or problems.

- Goals: The group therapy studies were evaluated by this Group Pentagon component relative to patient goals for each group and group goals for each group. Conclusion: None of the seven studies established individual patient goals for each group nor did they establish group goals for each group.
- Methods: This component of the Group Pentagon was used to describe procedures in each group and how these procedures were related to specific patient problems and goals. Procedures used in each group were specific to the theoretical concepts being studied in research projects that were on-going (person-centered, psychoanalytical, behavioral, problem solving, and object- relations). Conclusion: In these projects, all procedures were applied to all patients irrespective of specific patient behavior, problems, symptoms, or goals.
- Risks: This component of the Group Pentagon was used to determine if any studies identified or explained to patients risks or consequences of participation in that group therapy. Conclusion: None of the studies noted any manner of identifying or explaining risks of group therapy to patients.
- Evaluation: The group therapy studies were reviewed by this Group Pentagon component relative to the evaluation of individual patient progress per group, the evaluation of the group process, and the evaluation of the overall group therapy program. Four of the seven studies addressed outcome measures for patients in each group. The other three studies did not address patient progress per group at all. None of the seven studies addressed or described evaluation for the group process. None of the seven studies addressed or described evaluation for the overall group therapy program. Conclusion: There was minimal, if any, attention given to evaluation.

Summary of the Literature Using the Group Pentagon Components

Perhaps the most remarkable aspect of the literature review was the small number of studies relating to group therapy practices on general hospital psychiatric units. Next, across the available literature, patients were assigned to group therapies irrespective of a patient's behavior problems or symptoms. All models of group therapy in the review recognized the importance of goals, yet the creation of specific, patient-driven goals for each patient for each group and goals for each group were not addressed. Methods were almost always applied to all patients in the group without being related to specific patient behavior or goals. Risks or consequences of group

therapy were not addressed in the literature at all. Models or studies addressing evaluation of the group therapy process in any way were not evident. Across the available literature, there is a very clear lack of connection among current behavior, goals, methods, risks, and evaluation for group therapies being utilized on general hospital psychiatric units.

CHAPTER THREE

Methodology

Introduction

This chapter delineates methodological procedures for the present study. Research Questions are reviewed, the target population and participant selection procedures are presented, and the instrumentation is described. In addition, survey distribution, data collection, and data analysis methods are presented.

Specifically, the study used a survey and structured interviews to evaluate current group therapy practices in general hospitals, determine if components of the Group Pentagon are being used in current practice, and identify desirable components of effective group therapy. Data related to current practices were compiled through a survey given to Directors of psychiatric units; Group Pentagon components were addressed through combinations of survey data plus structured, on-site interviews with practitioners; and desirable components of effective group therapy were identified through structured, on-site interviews with group therapy practitioners in the hospital units.

Chapter 2 described a specific need for research to summarize the literature related to current practices of group therapy on general hospital psychiatric units and outlined critical components of a model to determine whether it could be used in designing, implementing, and evaluating group therapy on general hospital psychiatric units.

Research Questions

Procedures described in this chapter were derived from the following research questions for specified general hospital psychiatric units in a southeastern state:

1. What are the available statistical data relevant to general hospital psychiatric units utilizing group therapy as a customary modality of treatment?
2. What are the current group therapy practices in general hospital psychiatric units?
3. To what extent are the components of the Group Pentagon utilized in psychiatric units of general hospital group therapy?
4. What are the desirable components of group therapy as identified by practitioners of general hospital psychiatric unit group therapy?

Findings related to each question are presented in Chapter Four and discussed in Chapter and Five.

Participants and Selection Criteria

The population selected by the researcher for this study was all general hospital psychiatric units providing psychiatric inpatient services in a southeastern state as described by the Center for Mental Health Services, U.S. Department of Health and Human Services. A general hospital psychiatric unit was defined as a non-Federal hospital under private, non-profit, state or local government auspices that provides inpatient medical and surgical services as well as psychiatric services in a separate, psychiatric inpatient, and/or outpatient, and/or partial hospitalization service with assigned staff and space (Witkin et al, 1995).

Instrumentation

A Program Director at each of the general hospital psychiatric units was asked to complete and return a General Hospital Psychiatric Unit Survey. Group therapy practitioners, one each at the three largest and three smallest units returning the General Hospital Psychiatric Survey, were interviewed on-site using a standard interview protocol, by this researcher who conducted Group Therapy Practitioner Structured Interviews.

General Hospital Psychiatric Unit Survey: The General Hospital Psychiatric Unit Survey (GHPUS) (Appendix A) was used to gather information relevant to:

- (a) unit descriptions;
- (b) staffing;
- (c) patients; and
- (d) general concepts regarding unit group therapy practices.

A GHPUS was administered to the individual identified as the Program Director, Director, or Unit Manager. This individual typically was the person responsible for the overall administrative and clinical functions of the unit. The Director was the most knowledgeable person associated with the unit relevant to non-clinical, administrative aspects of the unit such as usage statistics, staffing, and operational standards and requirements.

(A) Hospital Description: To obtain information about the unit, participants were asked to specify their title and:

- 1. the license type of the unit;
- 2. the number of beds;
- 3. the average daily patient occupancy;
- 4. the voluntary and involuntary patient usage;
- 5. the average length of stay;
- 6. whether the unit was Diagnostic Related Group exempt; and
- 7. whether the unit was milieu based.

(B) Staffing: To compile staffing information, they were asked to describe:

- 8. professional staffing; and
- 9. the providers of group therapy.

(C) Patient Information: To summarize information about patients, they were asked:

- 10. the age ranges of patients;
- 11. the patient gender percentage;
- 12. the types of patients excluded from groups; and
- 13. the three most frequent diagnoses of patients.

(D) Group Therapy Concepts: To address concepts regarding group therapy practices, participants were asked:

- 13. to describe the basis for assigning patients to groups;
- 14. who establishes goals for each patient for each group;
- 15. how methods to be used in each group are determined;
- 16. to describe the primary process for determining which methods are to be used in each group;

17. if benefits/risks/consequences for each group are explained to the patient;
18. how benefits/risks, consequences are explained to the patient;
19. if behavioral changes are assessed for each patient for each group; and
20. who evaluates the overall group therapy program (see GHPUS, Appendix A).

Each GHPUS was numbered to correlate with a Master List of all units in the state. The Master List was known only to the researcher. Confidentiality was maintained throughout the study.

Group Therapy Practitioner Interviews: A total of six Group Therapy Practitioners received structured, on-site interviews involving 35 specific content items listed in the Group Therapy Practitioner Interview Protocol (Appendix B), in order to:

- (a) gather information related to specific unit Group Therapy Practices;
- (b) evaluate Group Pentagon components utilized in unit group therapy practices; and
- (c) identify desirable factors influencing unit group therapy practice.

(A) Group Therapy Practices: To gather information related to group therapy practices group therapy practitioners were asked:

1. the average number of patients per group;
2. the range of patients attending each group;
3. the average number of group therapies per week;
4. if all patients must attend groups;
5. if groups begin and end on time;
6. if groups have a constant meeting place;
7. the average number of group therapy sessions a patient attends prior to discharge;
8. if groups are undisturbed;
9. if groups are open versus time limited;
10. the length of group therapy sessions;
11. the types of group theoretical approaches used;
12. the most frequent group theoretical approach used;
13. who designs the group therapy program;
14. the types of and most frequent groups provided by the unit;
15. to describe the profession, degree, license, and years of experience of all providers of group therapy on the unit; and
16. to describe their own training in group therapy.

(B) Group Pentagon Components: To evaluate Group Pentagon components used in group practice, group therapy practitioners were asked:

17. to describe the process for assigning patients to group therapies;
18. if group goals for each group are developed;
19. how group goals for each group are developed;
20. if goals for each patient for each group are developed;
21. how goals for each patient for each group are developed;
22. who determines what procedures are to be used in each group;

23. how those procedures are determined;
24. if benefits/risks/consequences for each group are explained to the patient;
25. how risks/benefits/consequences for each group are explained to the patient;
26. how patient progress for each goal for each group is assessed;
27. if the group process for each group is evaluated;
28. if the overall group process is evaluated; and
29. how the overall group process is evaluated.

(C) Group Therapy Factors: Finally, to identify desirable factors leading to effective unit group therapy, group therapy practitioners were asked to:

30. describe desirable conditions for effective group therapy on a general hospital unit;
31. report which of those conditions were not available on their unit;
32. specify obstacles blocking the provision of effective group therapy on their units;
33. depict the extent that group therapy is influenced by managed care or third party payers;
34. describe the principal challenges facing group therapy on general hospital psychiatric units in the future; and
35. describe factors they believe will ensure the continuing presence of group therapy on these units into the future.

These structured interviews were conducted in the hospital setting with six group therapy practitioners. A group therapy practitioner was an individual in each hospital who participated in the design and direct delivery of group therapies. This person was highly knowledgeable of the design and implementation process for group therapy on a psychiatric unit. Practitioners from the three largest and three smallest units were involved to address possible variance in the results due to the size of the hospital facility and program.

Each interview was numbered to correspond to a Master List of the three largest and three smallest units returning the GHPUS. The Master List was known only to the researcher.

Survey Distribution and Structured Interviews

General Hospital Psychiatric Unit Survey: The General Hospital Psychiatric Unit Survey used in this study was distributed and collected by mail. The data collection process included an introductory telephone call to all Program Directors, the initial survey distribution, a personal phone call to all non-respondents of the initial mailing, and a follow-up mailing.

Five days prior to the first mailing of the survey materials, an introductory telephone call was placed by the researcher to the Program Director or the person administratively directing the Psychiatric Unit at each of the units across the state. General Hospital Psychiatric Unit Survey Procedures (Appendix C) were developed and followed for all contacts. The introductory telephone call included an introduction of the researcher and the study, a description of the nature of the study, a discussion of the benefits of participation in the study, questions and comments by the Program Director, and appreciation offered by the researcher for participation.

The initial mailing of survey materials occurred on May 28, 1997. Each packet contained an introductory letter (Appendix D), the General Hospital Psychiatric Unit Survey, two copies of the Informed Consent for Participation (Appendix E), and a stamped, self-addressed envelope. The introductory letter, from the researcher, briefly described the nature of the study, reported completion time, encouraged participation, assured confidentiality, and provided instructions for the Informed Consent for Participation. After reading the Informed Consent for Participation, the participant was to keep one copy while returning a signed and dated copy with the survey.

Four weeks after the initial survey mailing, a follow-up packet of materials was sent on June 26, 1997, to participants who had not responded by June 23, 1997. Each packet included an introductory letter (Appendix F), the General Hospital Psychiatric Unit Survey, and Consent forms. The letter again introduced the researcher and the study, and assured confidentiality. The packet again included a stamped, self-addressed envelope. The General Hospital Psychiatric Unit Survey portion of the study was closed on July 24, 1997.

Non-respondents (those units not responding by July 24, 1997) to the GHPUS were analyzed by number of beds and geographical location. This analysis is reported in Chapter Four.

Group Therapy Practitioner Interviews: The Group Therapy Practitioners were a vital part of the research process since they were involved in the design and delivery of group therapy. The data collection process included setting up the interview, conducting structured interviews, closing the interview, and follow-up. Since one purpose of this study was to test a model to determine if it could be used to evaluate current practices of general hospital psychiatric unit group therapy for future research, procedures for conducting the Group Therapy Practitioner Interviews were developed (Appendix G).

Following the closing of the General Hospital Psychiatric Unit Survey on July 24, 1997, the three largest units and three smallest units were selected. The largest and smallest units were used in order to determine whether the nature and methods of group therapy differed as a function of the size of the programs at different facilities. Size was based on number of beds. The researcher called the Program Director at each of the six units to request an appointment with a group therapy practitioner of the Program Director's choice at each unit. During this telephone conversation, the purpose of the Group Therapy Practitioner Interview was reviewed, confidentiality was assured, and participant time involvement was described. Following the telephone call, an appointment letter (Appendix H) was sent to the Program Director confirming the date, time, and place of the interview with the group therapy practitioner.

Upon meeting on-site with the group therapy practitioner, the researcher described the nature of the study, answered any questions, and presented the practitioner with the Informed Consent for Participation. One copy of the signed Consent was kept by the researcher. The Group Therapy Practitioner Interviews were then conducted by the researcher.

At the conclusion of the interview the researcher answered any questions and offered the practitioner a copy of the results. Additionally, appreciation for the practitioner's time was extended. At the conclusion of the study, a follow-up letter (Appendix I) with a copy of the results was sent to all participants.

Data Analysis

Data obtained from the General Hospital Psychiatric Unit Surveys returned by the Unit Directors was analyzed using frequencies, medians, means, and ranges. During the interviews with the group practitioners, the researcher recorded the responses of the practitioners on the Group Therapy Practitioner Protocol. That data was analyzed using frequencies, means, and ranges. Data from the General Hospital Psychiatric Unit Surveys and the Group Therapy Practitioner Interviews were combined and analyzed using means and ranges.

Summary

This chapter reviewed the research methods used in this study. Guided by the Research Questions stated at the beginning of the Chapter, a target population and participant selection procedures were described, instrumentation was reviewed, survey distribution and data collection procedures were presented, and data analysis procedures were noted.

CHAPTER FOUR

Presentation of Results

Introduction

This chapter describes the results of the data collection procedures delineated in Chapter Three. The first section examines the survey response for each step in the survey distribution process and the response for the entire study. The second section presents data collected from the responses to the General Hospital Psychiatric Unit Survey. The third section describes responses to the Group Therapy Practitioner Interviews. Next, data are summarized related to small versus large units. Finally, a synthesis of data is presented.

Survey Response

Data collection procedures were detailed in Chapter Three. Briefly, for the General Hospital Psychiatric Unit Survey, there were four steps:

1. an introductory telephone call to Program Administrators;
2. the initial survey mailing to all participants;
3. a follow-up telephone call to non-respondents; and
3. a follow-up mailing.

Of the 38 total programs listed in the southeastern state, three had been closed since the creation of the listing, leaving 35 total units still in operation. Return percentages for each data collection step are presented in Table 4.1. No packets mailed were returned by the U.S. Postal Service and the follow-up telephone call to all but two non-respondents revealed that administrators at each unit had received a packet.

During the follow-up telephone contact after the initial mailing, two administrators could not be reached after three attempts and the survey was thereupon mailed. The final response rate for the General Hospital Psychiatric Unit Survey, 80 percent, (n = 28), included 100 percent usable returns, with six questions with no response and one unintelligible question response.

Non-respondents to the GHPUS are described by number of beds and location of unit. In total, seven units did not respond to the survey. Beds per unit of non-responders were 14,18,20,20,22,24, and 40, representing a range of 14-40 and a mean of 23 beds per unit compared to a range of 12-54 and a mean of 26 across all responding units. All but one unit were from metropolitan areas, with four non-responders from the same city.

General Hospital Psychiatric Unit Survey

Responses to the General Hospital Psychiatric Unit Survey were used to describe psychiatric units, staffing patterns, and general concepts regarding unit group therapy practices. The variables are presented in the order in which they occurred on the GHPUS.

Responder Title

The General Hospital Psychiatric Unit Survey was directed to the administrator at each psychiatric unit. Table 4.2 presents the title descriptions by number and overall percentage.

Table 4.1

General Hospital Psychiatric Unit Survey Response Rates

Step	Number Contacted/ Returned	Percent of Total
Introductory Telephone Contact	35	100
Initial Mailing Return	20	57
Follow-up Mailing Return	8	23

Total Returned	28	80
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Table 4.2

Responder Title

Title	Number	Percent of Total
Director of Behavioral Health Services	7	25
Nurse Manager	5	18
Program Director	3	11
Director of Psychiatry	3	11
Coordinator of Family Services	2	7
Director of Psychiatric Services	2	7
Director of Mental Health	1	3.5
Patient Care Services Manager	1	3.5
Assistant Patient Care Manager	1	3.5
Director of Adult and Outpatient Services	1	3.5
Psychiatric Center Manager	1	3.5
Administrative Coordinator of Psychiatric Services	1	3.5
Total	28	100

There were 12 different titles across the 28 facilities for the person administratively designated as the Director. The most frequent title (25 percent) used was “Director of Behavioral Health Services,” closely followed by “Nurse Manager”(18 percent), “Program Director”(11 percent), and “Director of Psychiatry”(11 percent).

Unit License

Of the 28 responding units, 100 percent were licensed by the state for providing psychiatric inpatient services. Sixteen (68 percent) were licensed for providing psychiatric services only, none were licensed for providing only chemical dependency services, and 9 (32 percent) were licensed for providing both psychiatric and chemical dependency inpatient services.

Number of Beds, Locked versus Open

Total number of beds for the 28 responding units ranged from 12 to 54 with a mean of 26 beds per unit. Median number of beds per unit was 24. The range of locked unit beds ranged from 6 to 40 with a mean of 21 for those units being partially or full locked. The median number of locked beds per unit having locked beds was 20. Of the 28 responding units, all but three utilized locked beds on units either partially or fully locked.

Twenty units had no open beds. Open unit beds ranged from 10 to 43 with a mean of 27 beds for those units being partially or fully open. Only three units had no open beds.

Average Occupancy

The total average daily patient occupancy for all units ranged from 14 to 75 percent with a mean daily occupancy of 53 percent. This total included a range in the average daily occupancy of 33-75 percent (mean = 53 percent) per day on the locked units, 14-74 percent (mean = 54 percent) per day on the open units, 46-60 percent (mean = 54 percent) on units having both locked and open beds.

Patient Legal Status

One unit kept no records of percentages of voluntary versus involuntary patients. Of the 27 units responding, two did not admit involuntary patients. Average percentage of voluntary patients versus involuntary patients for those 25 units admitting both was 84 percent voluntary patients to 16 percent involuntary patients. The range for percentage of voluntary patients to involuntary patients on those units admitting both was 56/44 percent to 99/1 percent. The median percentage of voluntary to involuntary patients was 85 to 15 percent.

Length of Stay

The range for the average patient length of stay was 4 days to 12 days while the mean patient length of stay was 6.5 days. The median length of stay was 6 days.

Diagnostic Related Group Exemption

Diagnostic Related Group Exemption (DRG) is defined as the number of days a third party payer (insurance company, Medicare, Medicaid) pays for a patient to stay in the hospital, depending on the patient's diagnosis. A DRG exempt unit means the psychiatric unit does not have to conform to these payer limits.

Two of the 28 responding units did not report DRG Exemption status. Of the remaining 26 units, 22 or 85 percent, reported the unit was DRG Exempt. Of the four non-DRG Exempt units, the average length of stay was 4.5, with a range of 5-6.8 days, compared to an average length of stay of 6.8 and range of 4-12 days for DRG Exempt units.

Professional Staffing

Table 4.3 represents the number and percentages of professionals working on the units. All 28 units responded to the item. Eight hundred and ninety-two (892) staff were reported working on the 28 units for a mean number of 31.82 staff per unit. A variety of staffing patterns was apparent with one unit reporting all staff were independent contractors while others employed no independent contractors. Psychiatrists were primarily Independent Contractors (72 percent), as were Psychologists (65 percent). Counselors and Psychiatric Social Workers, though, were primarily employees (full or part-time) at 92 percent and 90 percent, respectively.

By type of employment, 498, or 56 percent, of staff were full-time employees of the hospital. Two hundred fifty-four (254) or 28 percent were part-time employees, and 140, or 16 percent were independent contractors. Nurses included Registered Nurses- Certified (RNC), Registered Nurses (RN), and Other. Nurses by far accounted for the largest number of staff with 623 or 70 percent of the staff. Of all RN's, only 20.6 percent were RNC.

Counselors and Psychiatric Social Workers accounted for a combined 11 percent of the total staff (4 and 7 percent). Psychiatrists accounted for 11 percent of the total staff but this does not reflect hours worked. Most Psychiatrists on inpatient units do not work 40 hour work weeks while most non-Psychiatric personnel do. Psychologists accounted for only 3 percent of all staff and were almost totally contractual staff, a statistic indicating a small utilization of this profession compared to other professions. Activity therapists comprise 5 percent of total staff and were primarily full-time (63 percent). The category, Other, represents non-licensed personnel including nursing assistants, nursing technicians, and nursing aides. This category represented 25 percent of all staff.

Providers of Group Therapy

This item requested by profession, degree, and combined years of group therapy experience, a description of the providers of group therapy. Of the 28 units responding, one response was unintelligible. One unit reported the term "group therapy" was not used, opting to use the term "group activity."

Table 4.4 reviews by percentage of total the providers of group therapy by profession and education, and the mean number of years of group therapy experience by profession and education. The largest group of providers by profession are nurses, comprising 65 percent of the total providers of group therapy on the 26 units. The combined mean number of years of group therapy experience for nurses was 4.2 with 4-year RN's and Master's level RN's having 8.4 and

Table 4.3

Professional Staffing

Profession	Number of Full-time Employees	Number of Part-time Employees	Independent Contractor	Total Number	Percent of Total Staff
Psychiatrists	24	3	70	97	11
Psychologists	7	2	17	26	3
Counselors	25	10	3	38	4
Psychiatric Social Workers	43	10	6	59	7
RNC	59	21	3	83	9
RN	177	123	20	320	36
Activity Therapy	31	17	1	49	5
Other	132	68	20	220	25
<hr/>					
Total	498	254	140	892	100

Table 4.4

Providers of Group Therapy

Profession	Associate Degree	Bachelors Degree	Masters Degree	Doctoral Degree	Percent of Total Providers	Mean Years of Experience
Psychiatrists	--	--	--	10	5	5.4
Psychologists	--	--	1	--	.5	3.0
Counselors	--	2	--	--	.9	10.0
	--	--	16	--	8	9.75
Psychiatric Social Workers	--	3	--	--	1	5.0
	--	--	29	--	14	7.4
Students with Co-therapist	--	1	--	--	.5	0
Without Co-therapist	--	--	2	--	.9	1
Nurses 2 year	79				38	2.7
4 year	--	36	--	--	17	8.4
RNC	--	13	--	--	6	4.5
Masters	--	--	6	--	3	8.0
LPN(1 Yr)	3	--	--	--	1	3.3
Total by Degree	82	55	54	18	99.8	
Total Providers				209		

8 years of experience, respectively, and 2-year RN's, who make up the largest percentage of group therapy providers, having a mean of 2.7 years of group therapy experience.

The largest category of non-nursing group therapy providers were Psychiatric Social Workers comprising 15 percent of the total and a mean of 7.2 years group therapy experience. Counselors were the next highest category of group therapy providers with 8.9 percent of the total providers and a mean 9.8 years group therapy experience. Psychologists, among non-nursing professionals, comprised the lowest percentage of group therapy providers at 4.5 percent with a mean combined years of experience at 9.6, followed by Psychiatrists with 5 percent of the total and a mean 5.4 years group therapy experience. One response could not be interpreted.

Patient Age

The percentage age ranges of patients treated in the facilities is reported in Table 4.5. Results are described by the mean percentage of patients per age category and by the range of the percentage of patients per age category. Two units reportedly kept no age-related records and one unit did not respond to the question.

That only 3.1 percent of all patients were under 18 was not surprising since the units surveyed were adult units. These units typically do admit a small percentage of under age 18 on an emergency basis before either providing crisis treatment only or initiating a transfer to an adolescent treatment unit.

Seventy-six percent of all patients fall into the 18-35 and 36-64 age ranges with the latter range comprising the highest group at 46 percent. The 64-84 age group comprised 19.9 percent while the 85+ age group made up 2.7 percent of the total.

The ranges of responses per age group were wide (0-25, 5-50, 25-70, 1-48, and 0-15) possibly indicating variance among the responders in the ages of patients treated or in the types of patients treated. None of the units treated a singular age range category.

Patient Gender

The percentage of male versus female patients ranged from 30 percent males to 70 percent females and 60 percent males to 40 percent females. The mean percentage male to female ratio was 41.8 percent males to 58.2 percent females. Female patients outnumbered male patients by a 3 to 2 margin. Three of the 28 units did not respond to this question.

Patient Exclusion from Group Therapy

One unit did not respond to this question. Thirty-three percent or 9 of the responding units reported some patients are typically excluded from group therapy. Sixty-seven percent or 18 of the units reported there are no patients excluded from group therapy, indicating a variety of patients/symptoms/diagnoses interface with the group therapy process. Reasons for excluding patients from group therapy included:

1. Patient actively psychotic (4 units reported);
2. Patient under involuntary commitment (2 units reported);
3. Patient in restraints or seclusion (1 unit reported);
4. Restrictive medical problems (1 unit reported);
5. Physically assaultive behavior (1 unit reported);

Table 4.5

Patient Age Ranges

Age Range	Mean Response	Range
Under 18	3.1%	0-25%
18-35	30%	5-50%
36-64	46%	25-70%
65-84	19.9%	1-48%
85(+)	2.7%	0-15%

One unit did not respond.

Two units did not keep age records.

6. Severe dementia (1 unit reported); and
7. Patient hospital dependent and group is seen by patient as reinforcement for dependent behavior (1 unit reported).

Patient Diagnoses

Table 4.6 describes the most frequent diagnoses of patients. All 28 units responded to this item. Some units did not respond with a diagnosis as requested but with a general term or a cluster of symptoms (i.e., psychosis). These general terms are reported as part of the results.

Relative to frequency of diagnoses and symptoms, the three most frequently listed were Depression, Bipolar Affective Disorder, and Schizophrenia. Twenty-seven (27) of the 28 units reported Depression as one of the three most frequent diagnoses, representing 32.5 percent of all diagnoses listed. Bipolar Affective Disorder was listed by 20 of the units representing 24 percent of all diagnoses listed. Schizophrenia was listed by 12 of the units and represented 14.5 percent of all diagnoses listed.

Depression was listed as the most frequent diagnosis by 22 units. Schizophrenia was listed by 5 of the units as the most frequent diagnosis. Dementia was listed as the most frequent diagnosis by one unit. The types of frequent diagnoses indicate that the units are treating many patients with chronic mental illnesses or organic disorders, and a much lesser percentage of functional disorders.

Patient Assignment to Specific Groups

This item represented the basis for which patients were assigned to specific groups. All 28 units responded to this item. Table 4.7 summarizes the alternative responses. The most frequent method of assigning patients to groups was by "Severity of dysfunction," 12, representing 25 percent of the total responses. "No criteria" and "All patients attending all groups" ranked next in frequency with 11 (22 percent), and 10 (20 percent) respectively. Together, these two responses comprise 42 percent of the total responses.

"Specific symptoms or functional impairments" followed with 9 responses (18 percent of total) and "Diagnosis" accounted for 5 responses or 10 percent of the total. The "Other" criteria had two responses for 5 percent of the total. The two responses labeled "Other" were 1) by treatment goals and 2) that geriatric patients had a special group track. There were no "Comments" to this item.

This item was also able to delineate singular responses, that is, if any one criterion was the method for assigning patients to groups. Eleven units listed patient assignment to groups based on one criterion. "No criteria" was listed by four units as being the method for assigning patients to groups. "All patients attend all groups" was listed by three units as the only method of assigning patients to groups. "Severity of dysfunction" was also listed by three units as the singular method. Finally, "Specific symptoms or functional impairments" was utilized by one unit as the means for assigning patients to groups.

Clearly, there is much variance in how units assign patients to group therapy. Some units use only one method and seven or 25 percent of the units either have all patients attend all groups or have no criteria for assigning patients to groups. "All patients attend all groups" may also mean no criteria are established for assignment. Twenty-one units use more than one

Table 4.6

Patient Diagnosis

Diagnosis	Frequency Reported	Percent Total of All Diagnoses
Depression (Major Depression, Dysthymia, Atypical)	27	32.5
Bipolar Affective Disorder	20	24
Schizophrenia	12	14.5
Psychosis	8	10
Dementia	5	6
Polysubstance Abuse	4	4.9
Generalized Anxiety Disorder	3	3.6
Post Traumatic Stress Disorder	2	2.5
Delirium	1	1
Alcohol Dependence	1	1
Total	83	100

Table 4.7

Patient Assignment to Groups

Criterion	Frequency Reported	Percent of All Responses	Frequency of Solitary Response
a. All patients attend all groups	10	20	3
b. Diagnosis	5	10	0
c. Severity of Dysfunction	12	25	3
d. Symptoms or Functional Impairments	9	18	1
e. No Criteria	11	22	4
f. Other*	2	5	0
Total	49	100	11

*Two "Other" noted methods of patient assignment to groups:

- 1) Treatment Goals
- 2) Geriatric patients have a special track.

criterion for assigning patients to groups. Additionally, criteria such as “Severity of dysfunction” and “Functional impairments” may be vague and definitions and standards may vary from unit to unit.

Who Establishes Patient Group Goals

This item asked participants who established goals for each patient for each group. Twenty-seven of the 28 units responded to this item. There were no “Comments” from any unit. Table 4.8 summarizes the responses to this item.

Of the 34 total responses, 15 representing 44 percent indicated no goals for each patient for each group were set. The “Group therapist and patient collaboratively” criterion was listed 8 times for 23 percent of the total. The “Treatment Team” establishing goals for each patient for each group comprised 5 responses for 15 percent of the total. The “Group Therapist Alone” set patient goals for each group on four units for 12 percent of the total while “Other” was listed by two units for 6 percent of the total. The “Other” remarks included 1) Patients set goals for themselves and 2) Treatment Team and patients set patient goals for each group.

Of the 27 units responding to the question, 12 or 44 percent of the units set no goals for each patient for each group. The scatter of responses by the other 15 units indicates a variety of methods used across the units for assigning goals for each patient for each group, when this is done.

Factors Determining Group Therapy Techniques

The determining factors for which methods or techniques are to be used in each group were addressed in this item. All of the 28 units responded to this item. Table 4.9 indicates that “Therapist expertise and familiarity with group procedures” is a determining factor in how group methods were chosen. This criterion was chosen 20 times representing 31 percent of all choices in determining which group techniques will be utilized. Indeed, five units or 18 percent of all the units responding chose this method as the only method of determining which group therapy procedures would be used. The only other method chosen as the only method for determining which techniques would be used in a group was “Specific symptoms or functional impairments.” This method was chosen by one unit.

The “Methods evolved as group progressed” was listed 12 times representing 18 percent of the total response. The “Therapist at the beginning of the group session” was listed 10 times for 15 percent, while “Specific symptoms or functional impairments” was listed 9 times for 14 percent of total responses. “Milieu at the beginning of the group” and “Groups scheduled 24 hours in advance” were each listed seven times for 11 percent of the total. There were no comments on this item.

Primary Factor for Determining Group Techniques

Table 4.10 presents the data reflecting the primary factor for determining which methods or techniques will be used in a group. The response denotes the factor which exerts the most influence on what methods or techniques will be used in a group. All 28 units responded to this question.

Table 4.8

Persons Who Establish Patient Group Goals

Criterion	Frequency Reported	Percent of All Responses	Frequency of Solitary Response
a. Group Therapist and Patient	8	23	5
b. Group Therapist	4	12	2
c. Treatment Team	5	15	3
d. No Goals for Each Patient for Each Group Are Set	15	44	12
e. Other*	2	6	1
Total	34	100	23

* Patients Alone Set Goals
Treatment Team and Patient Set Goals

Table 4.9

Factors Determining Group Therapy Techniques

Method	Frequency Reported	Percent of All Responses	Units Indicating This Was the Only Method
a. Specific Symptoms or Functional Impairments	9	14	1
b. Therapist Expertise and Familiarity	20	31	5
c. Scheduled Greater Than 24 Hours in Advance	7	11	0
d. Therapist at Beginning of Each Session	10	15	0
e. Milieu at Beginning of Group	7	11	0
f. Methods Evolve as Group Progresses	12	18	0
g. Other	0	0	0
Total	65	100	6

Table 4.10

Primary Factor for Determination of Group Therapy Techniques

Criterion	Frequency Reported	Percent of All Responses
a. Specific Symptoms or Functional Impairments	7	25
b. Therapist Expertise and Familiarity	14	50
c. Scheduled Greater Than 24 Hours in Advance	0	0
d. Therapist at Beginning of Each Session	3	11
e. Milieu at Beginning of Group	4	14
f. Methods Evolve as Group Progresses	0	0
g. Other	0	0
Total	28	100

“Therapist expertise and familiarity with group therapy techniques” was chosen by 14 (50 percent) of the units as the primary method for determining which methods were to be used in a group. Group therapy methods based on “Specific symptoms or functional impairments” was chosen by seven units representing 25 percent of the units. “Milieu at the beginning of the group” and “By therapist at the beginning of each session” were the only other alternatives chosen at 4 (14 percent) and 3 (11 percent) respectively. One comment indicated that on one of the larger units, there were five different “group tracks” based on levels of functioning. A patient’s placement in a track was decided when the patient was admitted to the hospital and usually did not change, regardless of symptom change.

Benefits/Risks/Consequences Explained to Patient

This item questioned whether the potential risks, benefits, or consequences of each group therapy were explained to the patient. Additionally, if and how the method was documented was assessed. All of the 28 units responded to the question. There were no comments to this question.

There were 32 total responses to this item. Fourteen responses representing 44 percent of the total responses were for “No explanation provided.” This alternative was also listed by 14 different units representing 50 percent of all the units reporting no explanation was provided to patients relative to the potential outcomes of their involvement in a particular group therapy. In addition, the “Other” alternative was listed seven times with five explanations that “potential outcomes were described in the Patient Handbook” and two “Other” explanations that “the Treatment Team explained to the patient at the beginning of treatment the consequences of all group therapies.” Both “Other” alternatives indicate that specific explanations to a patient for each group attended was not provided. Therefore, the seven “Other” responses were similar to the “No explanation provided” alternative resulting in 21 (14 + 7) or 66 percent of the total 32 responses indicating that no explanations were provided to the patient.

The alternative “In group setting with all patients” was listed on eight occasions representing 25 percent of the total response. Only three of the responses indicated the explanations were documented. “Individual conference with patient” and “Written and verbal explanation provided” had 2 (6 percent) and 1 (3 percent) responses, respectively. None of these responses indicated documentation was provided. Consequently, explanations about the consequences of group therapy were usually not provided, and when explanations were provided, they were usually not documented.

Assessment of Patient Behavioral Changes for Each Group

This item related to how behavioral changes for each patient for each group were evaluated. All 28 units responded to this item. Also, if and how the evaluations were documented was queried. There were no “Comments” to this item.

There were 42 total responses to the question. Nineteen (45 percent) indicated evaluation of behavioral changes per patient per group was accomplished through “Observation by the therapist.” The response also noted that 14 of the 19 responses were documented, all in group notes in the patient’s chart.

Eleven responses (26 percent) noted “No assessment done,” also indicating that 11 of the 28 units (39 percent) provided no evaluation for patient responses to specific groups. “Oral report” and “Collaboratively between patient and therapist” each garnered 5 responses representing 12 percent of the total responses.

Two responses reported “Pre/post tests” were used to address behavioral changes per patient per group. One explanation was “Patient lists needs during initial stages of treatment and indicates at discharge how well these needs were met.” This explanation did not appear to relate to evaluation per patient per group. The other explanation was the “Clarity Health Assessment” which was administered indicating that assessment per patient per group was done.

On 39 percent of the units, no evaluation per patient per group was provided. The primary method of evaluating behavioral change was by the therapist processing observations, a possibly subjective procedure. Twenty-six percent of these types of evaluations were not documented. Only 6 responses indicated there was either a collaboration between patient and therapist or a Pre/Post test was used.

Group Therapy Program Evaluation

This item asked participants to describe who evaluated the overall group therapy program. Table 4.11 summarizes the data. All of the 28 units responded to this question. There were no “Comments” to this item.

Of the 33 total responses to this item, 11 (33 percent) indicated the group therapy program was not evaluated at that hospital. Of the remaining 6 alternatives to the question, there was an apparently even spread of responses. The group therapy program was evaluated by the “Treatment Team” 7 times (21 percent), the “Program Director” 6 times (18 percent), the “Group Therapists” 4 times (12 percent), a “Combination of the Program Director, the Medical Director, and the “Treatment Team” 3 times (10 percent), and “Other” 2 times (6 percent). The two “Other” responses were: 1) “Patients at discharge,” and 2) “Nurse Manager and group therapists.”

In summary, one-third of the programs were not evaluated and of those that were evaluated, a variety of individuals conducted the evaluation. Interestingly, the Medical Director, the individual normally charged with directly supervising the entire clinical operation of the unit, was not listed one time as the person who evaluated the overall group therapy program.

Group Therapy Practitioner Structured Interview

Responses to the Group Therapy Practitioner Interview Protocol, administered to six group therapy practitioners on-site at the practitioner’s psychiatric unit by the researcher following a standard interview protocol, were used to gather information relevant to specific group therapy practices, to evaluate if Group Pentagon components are utilized in general hospital group therapy practices, and to identify desirable factors as well as constraints influencing general hospital group therapy practice. The variables are presented in the order in which they occurred on the Group Therapy Interview Protocol.

Table 4.11

Group Therapy Program Evaluator

Criterion	Frequency Reported	Percent of All Responses
a. Program Director	6	18
b. Medical Director	0	0
c. Treatment Team	7	21
d. Combination of Above	3	9
e. Group Therapists	4	12
f. Program Not Evaluated	11	33
g. Other*	2	6

Total 33 99

* Two "Other" noted responses
1) Patients on Discharge
2) Nurse Manager and Group Therapists

Group Therapy Practices

The practitioners, during the interview process, described specific group therapy practices and procedures on their units. Their responses were recorded on Questions 1-16 of the Group Therapy Practitioners Interview Protocol.

Patients per Group

Across all units, the average number of patients per group therapy session was 6.3. The range in the average number of patients per group was 5 to 8. For the smaller units, the average number of patients per group was 6.3, with a range of 5-8. For the larger units, the average number of patients per group was 6.3 with a range of 5-7. Essentially, there was no difference between smaller and larger units in patients per group.

Range of Number of Patients per Group

The ranges in the number of patients per group conducted by each practitioner was 2-6, 2-10, 2-12, 2-12, 3-12, and 3-12. Therefore, the mean range in the number of patients per group across all groups was 2.67 to 10.67. Among smaller units, the mean range of patients per group was 2-12 and for larger units, the mean was also 2-12. There was no difference between smaller and larger units.

Group Therapies per Week

The average number of group therapies per week was 26.3. The range of the number of group therapies per week was 13 to 35. Among smaller units, the mean number of group therapies per week was 26 with a range of 13-35. For the larger units, the mean number of group therapies per week was 26.7 with a range of 22-29. Smaller units appear to have a wider range of groups per week but the number of groups per week vary very little from small to large units.

Patient Attendance

Of the six practitioners surveyed, 4 reported that it was mandatory that all patients attend all groups and 2 indicated that it was not mandatory. Exceptions cited by the two practitioners included 1) Psychotic patients did not have to attend and 2) The policy was that all patients attend all groups but it was not usually followed. The smaller and larger units had identical responses resulting in no size difference for this item.

Group Punctuality

This item related to whether groups began and ended on time. Four of six or 67 percent of the practitioners reported group therapy did not begin and end on time. The four reporting the time problems indicated the problem was very distracting and disturbing, to the point that some groups would last less than half the scheduled time. There was no difference in response between larger and smaller units with both reporting punctuality problems on 2 of 3 units.

Meeting Place

This question queried whether groups had a constant meeting place. Constancy in meeting place was reported by 83 percent, or 5 of the 6 respondents. Group therapy was conducted on,

not off, each unit in rooms designated as group therapy rooms, a practice resulting in very little variance among meeting areas. Between smaller and larger units, 2 of 3 smaller units reported a constant meeting place while all larger units reported a constant meeting place. Construction on the lone smaller unit resulted in changes in the group therapy meeting rooms.

Sessions Attended Prior to Discharge

Participants were asked to average the number of group therapy sessions a patient attended prior to discharge. The range in reported average number of group therapy sessions attended was 14 to 32. The mean number of group therapy sessions a patient attended prior to discharge was 25. Between smaller and larger units, the mean attendance for smaller units was 25.3 and the mean attendance for larger units was 24.7, a difference of .6 of one group.

Disruption of Groups

Participants were asked whether once begun, groups were undisturbed. Four of the six participants (67 percent) reported that some disturbance occurred in group therapy sessions after they had begun. All six practitioners indicated this was currently or had been a very serious problem in their units with interruptions from other hospital personnel (lab, physical therapy, physicians) rather than interruptions caused by patients. The interruptions were at times so severe and frequent that groups would be terminated early. Between smaller and larger groups, there was no difference in response with both categories reporting that 2 of 3 units had groups that were disturbed.

Open-ended versus Time-limited

Participants were asked about the provision of open ended and time limited groups. Open-ended groups are not limited to a specified number of sessions or limited to a specified time period. Time limited groups run for a specified number of sessions or over a specified period of time. One hundred percent, or all of the six respondents, reported they provide open-ended groups. There were no units or practitioners providing time limited groups, either singularly or in combination with open ended groups. There was no difference in the responses of smaller and larger units.

Length of Sessions

This item related to the length of the group session. Five of the six practitioners reported the standard amount of time allotted for a group session was one hour. One practitioner indicated groups generally lasted about 45 minutes. All six practitioners claimed that sometimes groups may run a little longer but the opposite was more likely the case. That is, groups would more likely run a little less time than was allotted.

Between smaller and larger units, the only difference was one smaller unit practitioner indicating groups generally lasted 45 minutes rather than one hour. There were no "Other" responses to this question.

Group Therapy Theoretical Approaches

Items 11 and 12 questioned the theories and most typical group therapy approaches used on the six units. Table 4.12 describes the types of theoretical group therapy approaches used by the practitioners. Of 12 total responses there were seven different theories named.

The cognitive-behavioral approach was named five times representing 42 percent of all responses. Affective and interactive approaches were each listed 2 times representing 17 percent each. Experiential, Gestalt, and Insight were listed one time for 8 percent each. Between smaller and larger units, the smaller units reported seven different theoretical approaches to five reported on the larger units. The cognitive-behavioral approach was the most frequently utilized approach on each unit.

Also indicated in Table 4.12 is the most typical theoretical approach used by the practitioners. The most typical theoretical approach is that theory of group therapy which is most frequently followed. The cognitive-behavioral theory was the most typical approach used by both smaller and larger units.

Who Designs Group Therapy Program

The six group therapy practitioners were asked who designed the overall group therapy program at their institution. The response, "Treatment Team", named twice, was the only one listed on more than one occasion. Named one time were "Program Director", "Group leaders", and "Clinical Director". Also named one time was the alternative "No one". Between smaller and larger units, "Treatment Team" was listed one each and there were then two other responses named once. These responses indicate a variety in the responsibilities across the six units for who designs the group therapy programs.

Types of Groups Table 4.13 summarizes the types and frequency of groups provided on the practitioners' units. Among all the groups there were 117 responses indicating 37 different types of groups were being conducted. The most frequent types of groups provided, each on all six units, included cognitive-behavioral groups, process groups, relaxation groups, goal setting groups, medicine education groups, and coping skills groups.

Provided on five of the six units were assertiveness training groups, eclectic groups, problem solving groups, decision making groups, and psychoeducational groups. Of these eleven types of groups offered on at least five of the six units, all have a very prominent didactic aspect. Indeed, practitioners clearly indicated that group practice had become more didactic and education oriented, with "psychoeducational" groups becoming much more frequent.

There were a wide variety of groups offered across the six units (117 responses, mean equal 19.5 different groups per unit). Of the 37 different types named, 20 were listed on one-half or less by the units, indicating a wide scatter of responses. The only "Other" group types listed were 1) Conversation skills, and 2) Self esteem, each on one unit.

The smaller units had 52 responses while the larger units had 65 responses. This may be expected as larger units could experience a greater diversity of patient symptoms and problems, thereby requiring a greater diversity in the group offerings. Additionally, with more patients, there was a need for an increased number of groups to be offered (maximum of 8-10 patients per session) so as to ensure all patients received the same number of groups each day. These two

Table 4.12

Group Therapy Theoretical Approaches

	Theory	Units Reporting Theory Used	Most Frequently Used Theory
Smaller Units	Cognitive-Behavioral	3	Cognitive-Behavioral Reported by All 3 Units
	Affective	2	
	Experiential	1	
	Gestalt	1	
Larger Units	Cognitive-Behavioral	2	Cognitive-Behavioral Reported by 2 of 3 Units
	Interactional	2	
	Insight-Oriented	1	
	Total	12	

Table 4.13
Types of Groups in Six General Hospital
Psychiatric Unit Group Therapy Programs

Type of Group	Number of Units Reporting	Type of Group	Number of Units Reporting
Medicine Education	6	Guided fantasy	2
Process	6	Behavioral	2
Cognitive-behavioral	6	Task	2
Relaxation	6	Art therapy	2
Goal setting	6	Discharge planning	2
Coping skills	6	Mens'	2
		Solution focused	2
Assertiveness	5	Gestalt	2
Eclectic	5	Crafts	2
Problem solving	5	Symptom management	2
Decision making	5	Rogerian	2
Psychoeducational	5	Womens'	2
Stress management	5		
		Future planning	1
Interactional	4	Focus	1
Movement	4	Awareness training	1
Family	4	Human sexuality	1
Social Skills	3	Other	
Living Skills	3	Conversational skills	1
Interpersonal skills	3	Self esteem	1
		Total	117

factors led to the increased number of group therapies on larger units.

Rank Order of Frequency of Types of Groups Provided

Table 4.14 summarizes the rank ordering of frequency of types of groups provided. To determine rank order, the practitioner chose which group was provided most frequently, second most frequently, and third most frequently. In rank ordering the three most frequent types of groups, cognitive-behavioral groups were clearly the most frequently provided type of group, having been ranked first by four units. One unit rank ordered coping skills groups as the most frequently provided type of group and one unit rank ordered problem solving groups as the most frequently provided type of group.

Of the seven different types of groups chosen, five (cognitive-behavioral, problem solving, coping skills, stress management, and psychoeducational) have major teaching or educational components and are less discussion oriented. Consequently, the most frequent types of groups provided are more psychoeducational and less patient discussion or patient interactional oriented. Practitioners from small and large units equally rank ordered cognitive-behavioral groups first.

Group Therapist Characteristics

This item related to the academic and experiential aspects of all of those individuals providing group therapy on the practitioners' units, as reported by the practitioners. Table 4.15 summarizes, by profession, degree, licensure/certification, and average years of group therapy experience, all providers of group therapy on the six group therapy practitioners' units.

The highest numbers of group providers are in the Nursing category (RN's and LPN's) with 17 providers listed (14 RN, 3 LPN). All were registered or licensed. The Nurses had a combined 4.1 years of group therapy experience.

Social Work comprised the next highest category of group therapy providers with a total of 12 providers and an average 9.3 years of group therapy experience. Counselors ranked third in number of therapy providers with 5 and 9.6 years of group therapy experience. Psychologists and Psychiatrists each had one group therapy provider with 10 and 15 years group therapy experience, respectively. All providers in all categories were licensed or certified by their profession except three Social Workers under supervision for licensure and one Social Worker not under supervision.

Eleven of 12 Social Work providers held Masters degrees and one had a Bachelors degree. Four Counselors held Masters degrees and one had a doctorate. All 3 Psychologists were doctoral level. Twelve of the 17 Nurses had Associate degrees (2 year degree) and three (LPN's) held one year degrees. Only two of the Nurse providers had Bachelor's degrees.

Practitioner Training

This question asked about the group therapy practitioners' training in group therapy theory and techniques. Table 4.16 lists, by size of unit, the types of training of the group therapy practitioners. All six practitioners had at least one class in Group Guidance and Counseling Procedures, but one took the class as an undergraduate and had no graduate classes. One other practitioner had only one graduate class (Group Counseling and Guidance Procedures) while the

Table 4.14

Rank Order of Frequency of Types of Groups Provided

Type	Order	Frequency
Cognitive-Behavioral	1st	4
	3rd	1
Problem Solving	1st	1
	2nd	1
Coping Skills	1st	1
	2nd	2
	3rd	2
Process	2nd	1
	3rd	1
Stress Management	2nd	2
Interactional	3rd	1
Psychoeducational	3rd	1

Table 4.15

Group Therapist Characteristics

Profession	Degree	Number of Providers	Licensed	Average Years of Group Experience
Social Work	MSW	8	Yes	12.3
	MSW	3	No	4.0
	BSW	<u>1</u>	No	<u>1.0</u>
		12		9.3
Counseling	PhD/EdD	1	Yes	27.0
	Masters	3	Yes	11.0
	Masters	<u>1</u>	No	<u>9.0</u>
		5		9.6
Psychology	PhD	<u>3</u>	Yes	<u>10.0</u>
		3		10.0
Registered Nurse	Associate	12	Yes	4.3
	Bachelors	2	Yes	6.0
Licensed Practical Nurse	One Year	<u>3</u>	Yes	<u>2.0</u>
		17		4.1
Psychiatrist	Medical Degree	1	Yes	15.0
	Total	38		7.2

Table 4.16

Training of Group Therapists

Smaller Units	Larger Units
1. One Graduate Class (Procedures)* One Seminar On-the-job Training	1. Two Graduate Classes (Procedures and Techniques)** Three Seminars On-the-job Training
2. Two Graduate Classes (Procedures and Techniques) Two Seminars On-the-job Training	2. Two Graduate Classes (Procedures and Techniques) No Seminars On-the-job Training
3. Two Graduate Classes (Procedures and Techniques) No Seminars On-the-job Training	3. One Undergraduate Class (Procedures) No Seminars On-the-job Training

* Procedures = class titled "Group Counseling and Guidance Procedures"

** Techniques = class titled "Advanced Group Counseling Techniques"

other four practitioners had two graduate classes that included Advanced Group Counseling Techniques as well as one class in Group Counseling and Guidance Procedures. Three of the six practitioners reported they had attended from 1-3 seminars or conferences on group theory or technique while three reported they had never attended a group therapy seminar or conference.

All practitioners reported they had “On-the-job training” for groups, usually during their initial years of professional work as they were progressing toward licensure in their profession. When asked to describe on-the-job training, all reported that it was like, “just being thrown out there doing groups mainly by yourself, sometimes with minimal supervision, and learning from your mistakes”. Group therapy practitioners at smaller units reported a slightly greater amount of academic and seminar instruction in group therapy when compared to larger units.

Group Pentagon Components

Questions 17-29 of the Group Therapy Practitioners Interview Protocol focused on whether and how the five components of the Group Pentagon were being utilized in current general hospital group therapy practices. Table 4.17 reviews and separates the responses of the six practitioners, obtained during the on-site interview, into the five Group Pentagon components that are used to assess the group process.

- Current Behavior: Five of the six practitioners indicated patients attend all groups, usually without regard to specific patient problems or goals. Two of the six practitioners indicated attendance and assignments to groups are based on subjectively assessed levels of patient functioning. Two of the six practitioners reported some patients, such as the acutely chemically influenced or the floridly psychotic, are excluded from group attendance. Specific statements made during the interview relative to this component include:

- 1) “Everybody goes”;
- 2) “All patients who can go, go”;
- 3) “If they are here, they go to group”;
- 4) “Are they awake?”;

One practitioner reported the Treatment Team each day schedules the groups for the day and assigns patients to the various groups based on current symptoms and identified problems. Patients were not required to attend all groups at this facility. The practitioners cited time constriction as the primary cause for not planning assignments to groups based on more relevant or therapeutic criteria.

- Goals: Five of the six practitioners indicated group goals for each group were not established. One practitioner reported goals for each group are set by the Treatment Team at the beginning of the week. Three of the six units reported there were no specific goals for each patient for each group established. Two of the six indicated patient goals for a group were established at the beginning of each group between the therapist and patient. These goals were verbalized and not documented. Two of the six practitioners claimed specific goals for each group were sometimes addressed in general terms on the patient’s treatment plan. Again, the practitioners cited time constraints as the biggest obstacle to setting goals.

TABLE 4.17

Therapeutic Practices and Group Pentagon Categories as Assessed by the Group Therapy Practitioner Interview Protocol

PROGRAM	CURRENT BEHAVIOR	GOALS	METHODS	RISKS	EVALUATION
1	All patients attend all groups	Patient goals set at group start No group goals set	Eclectic, determined by group leader based on familiarity & expertise of the therapist and patient current needs	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
2	All patients attend all groups Some assignment based on levels of functioning	No patient goals for each group No group goals for each group	Eclectic, Treatment Team suggests but group leader sets based on familiarity & expertise of the therapist	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
3	All patients attend all groups	No patient goals for each group No group goals for each group	Eclectic, determined by group leader based on familiarity & expertise of the therapist	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>

4	All patients attend all groups except floridly psychotic	Patient goals at group start based on symptoms No group goals for each group	Eclectic, determined by group leader based on familiarity & expertise of the therapist	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
5	All patients attend all groups except floridly psychotic and intoxicated	No patient goals for each group No group goals for each group	Eclectic, determined by group leader based on familiarity & expertise of the therapist and symptoms of patient	Not discussed with patient	Patient progress- <u>No</u> Group process- <u>No</u> Overall program- <u>No</u>
6	Treatment Team assigns each patient to each group based on symptoms Patients do not attend all groups	Goals for each patient for each group set by Treatment Team based on symptoms Goals for each group set by Treatment Team	Eclectic, determined by group leader based on familiarity & expertise of the therapist and needs of patients at group time	Not discussed with patient	Patient progress- <u>Yes</u> Group Process- <u>No</u> Overall program- <u>No</u>

- Methods: Five of the six practitioners reported the group leader determined the actual methods and techniques to be used in a group. Groups on all units are typically scheduled one week in advance and are part of an ongoing schedule of groups, sometimes used for months at a time. All units have the flexibility to drop, add, or modify the group schedule as needed, but practitioners noted there was very little variance in the schedule. One practitioner described the Treatment Team as determining the methods for groups but upon continued discussion, clarified this to indicate the Treatment Team suggested methods but those methods used are actually determined by the group leader.

Ultimately, then, the group leader on all the units determined the methods or techniques to be used in the groups. Relative to the procedures used in groups:

- 1) All practitioners described their group therapies as eclectic;
- 2) The determination of the methods, for all six practitioners, is at least partially based on therapist familiarity and expertise with the group methods; and
- 3) Three of the practitioners simply replied that methods are totally based on those techniques with which the therapist is most comfortable and familiar. They cited examples of :

- (a) doing the same psychoeducational group repeatedly, week after week, that incorporated a lecture on stress management; and
- (b) conducting the same cognitive behavioral lecture, week after week.

The other three practitioners, while also expounding the frequency of therapist determination of methods by familiarity and expertise, indicated the determination of methods to be used in groups were influenced by their judgment of patient needs by the therapist at the beginning of the group, current symptoms of the patients, or by what patients had requested in group techniques.

- Risks: Five of the six practitioners reported no explanations were issued for patients, families, or guardians relative to potential benefits or negative consequences associated with group therapy. Some suggested explanations were done on admission to the unit or in patients' handbooks and certainly not on a group to group basis. All acknowledged this was not documented.

One of the six practitioners indicated risks or consequences of group therapy were explained to all patients during the group, and this explanation was documented in a progress note in the patient's medical record. Apparently, this disclosure of risk was a standard procedure within the group therapy practice.

- Evaluation: Five of the six practitioners reported there was no evaluation of patient progress for each goal for each group. All six also reported there was no evaluation of the process for each group. Five of the six indicated the overall group therapy program was not evaluated. One of six acknowledged the overall group therapy program was "occasionally" evaluated by the Treatment Team but this was not a formal process. Of 18 possible responses to the evaluation of patient goals, group process, and the overall group therapy program, 17 indicated there were no evaluation procedures in place.

All practitioners cited the lack of time and the absence of a workable model to conduct such assignments to groups, setting of goals, determination of symptom driven techniques, explaining consequences to patients, and performing evaluations on group processes and programs.

Group Therapy Factors

During the interview process, the group therapy practitioners reviewed and discussed the factors they believed were necessary for the effective provision of general hospital group therapy. Their responses were recorded on Questions 30-35 in the Group Therapy Practitioner Interview Protocol.

Delineation and Presence of Desirable Factors

The practitioners were asked to describe desirable conditions for providing effective group therapy on their units. Table 4.18 summarizes the responses. The following list includes specific recommendations made by the six practitioners:

- 1) "No distractions or interruptions" -- 5 Practitioners;
- 2) "Well trained staff" -- 5 Practitioners;
- 3) "All level staff support" (administration and clinical) --3 Practitioners;
- 4) "More homogeneous patients" -- 3 Practitioners;
- 5) "Patients and groups being on time" -- 2 Practitioners;
- 6) "Control of milieu" -- 1 Practitioner;
- 7) "Group based on patient needs" -- 1 Practitioner; and
- 8) "Confidentiality" -- 1 Practitioner.

All practitioners noted significant changes in the past 5-10 years in the manner in which group therapy was being conducted. Increased documentation, decreased length of stay, less insight oriented groups, and increased psychoeducational groups were described as some of the major changes leading to the current state of practice.

There does not appear to be an appreciable difference in smaller versus larger units on this question. One smaller unit listed "Confidentiality" as a desirable condition. Further exploration of this response resulted in the practitioner noting the unit was in a hospital in a very small town and there had been some issues with many of their patients knowing or being related to each other.

Of the 21 possible desirable conditions for group therapy reported by the practitioners and listed in Table 4.18, 15 were not present on their unit. "Well trained staff" and "Minimal distractions/interruptions" were listed as not in place by five of the practitioners. Results indicated that these general hospital group therapy practitioners' units function without the presence of many factors which the practitioners consider desirable for effective group therapy.

Obstacles to Effective Group Therapy

Table 4.19 describes the practitioners' opinions about the obstacles to providing effective group therapy on general hospital psychiatric units. Five of the practitioners reported "Undertrained staff" as the major challenge in providing effective group therapy. Cited were examples of groups being conducted by staff with minimal academic training and sometimes, no supervision. That group therapy was provided by staff with one and two year degrees, no group

Table 4.18

Delineation and Presence of Desirable Conditions for Group Therapy

Response	Frequency Reported/ Large Units	Frequency Reported/ Small Units	Total	Not Present on Unit
No Distractions/Interruptions	3	2	5	5
Well Trained Staff	2	3	5	5
All Level Staff Support	2	2	2	2
Patients and Groups on Time	1	1	2	2
Control of Milieu	1	0	0	1
Groups Based on Patient Needs	0	1	1	1
Confidentiality	0	1	0	1
More Homogeneous Patients	1	2	1	3
Total	10	11	21	15

Table 4.19

Obstacles to Effective Group Therapy

Obstacles	Frequency Reported/ Large Units	Frequency Reported/ Small Units	Total	
Undertrained Staff	3	2	5	
Distractions/Interruptions	2	2	4	
Excessive Documentation	3	0	3	
Lack of Financial Support	1	1	2	
Heterogeneity of Patients	2	0	2	
Length of Stay	3	2	5	
Lack of All Level Staff Support	0	1	1	
Group and Patient Tardiness	2	2	4	
Use of Medical Model		1	1	2

Total 17 11 28

therapy classes of any type, and minimal, sometimes no structured on-the-job training, was very alarming to the practitioners. The need for more frequent, structured group supervision was suggested by all five.

“Patient average length of stay” was also reported by five of the six practitioners as being a significant barrier to effective groups. Some units, on the General Hospital Psychiatric Unit Survey, reported length of stay had decreased to 4-5 days. The practitioners explained that many groups had to be more education directed because there was no longer time to explore underlying causes of symptoms or to discover the etiology of emotional disturbances and illnesses. Although not the rule, it was not unusual to treat a patient with two individual sessions and three group sessions prior to discharge. Some practitioners described their group therapy as “guerrilla group therapy”, in that they had to strike quickly at the patients' problems before the patient was gone.

“Distractions and interruptions” was frequently noted (4 practitioners), a problem previously discussed. Similarly, “patients and groups not being on time” was again frequently cited (4). These two issues were described as being highly disruptive to the group process and according to the practitioners, occasionally resulted in groups being terminated prematurely or not run at all.

“Too much documentation” was noted by three practitioners as being a major obstacle. Explanations revealed that documentation requirements for third party payers have apparently increased in volume and complexity, to the point that it was common for documentation of the group process to take longer than the group itself. “Lack of financial support”, “Heterogeneity of patients”, “Use of medical model”, and “Lack of all level staff support” were listed by two or fewer of the practitioners.

Third Party Payer Influencing

This question explored the nature and extent to which managed care, insurance companies, or other payers had influenced group therapy on the practitioners' units. All six practitioners reported dramatic decreases in patient length of stay which resulted in groups being less focused on etiology and more on symptom relief. More educationally directed groups were again mentioned as becoming the mainstay of the group therapy programs. Increased documentation, groups being run seven days a week, and more groups per day were mentioned as results of third party demands. As an added note, the practitioners indicated there had been no evaluation of the extent to which symptoms change as a result of the above named consequences of third party payer influencing.

In summary, the practitioners believed third party payers had exerted a major influence on how they provide group therapy. Concern about the future of inpatient group therapy being influenced by third party payers was expressed by all.

Principal Challenges

This item addressed the practitioners' opinions about the principal challenges facing general hospital group therapy in the future. Four of the six practitioners indicated ability to adapt to shorter patient length of stays and dealing with managed care were the primary challenges for the future. They added that inpatient care had become more crisis reduction oriented and less oriented to treatment resulting in long term change of the patient. The frequency

of these responses was in line with concerns expressed in previous questions. The development of effective models of group therapy, new procedures to deal with documentation needs, increased time demand on staff, dealing with government influence in patient health care, and dealing with more severely disturbed patients were described by the practitioners as challenges in the future.

Group Therapy Future Viability

Practitioners were asked to describe the factors they believed would ensure the viability of general hospital group therapy into the future. Four of six practitioners indicated that “Well trained staff” and “Workable models of group treatment and documentation” were the primary factors that would ensure group therapy survival. That group therapy be “Accepted as a valuable component of treatment” was listed by three practitioners and related to concerns that group therapy may not be adequately accepted as a viable treatment modality. An attitude of “Put the patients in group so we can get some things done” was reported and reduced group therapy to a “babysitting “ service.

Also cited by the practitioners was “Successful negotiation with third party payers” and “Cost effectiveness of group therapy”. These two factors related to the financial constraints on these units to increase revenue and decrease expenses. All the practitioners reported negotiation with third party payers for approval for continued patient treatment was a therapist responsibility and was very time consuming, sometimes interfering with their time to provide therapeutic activities.

Small versus Large Units

As it relates to the differences between smaller and larger units, fifteen variables were compared. Variables compared included:

- 1) Patients per group;
- 2) Range of patients per group;
- 3) Group therapy sessions per week;
- 4) Patient attendance (indicating whether patients were required to attend groups);
- 5) On time (indicating whether groups were reported as starting on time);
- 6) Meeting place (indicating whether groups consistently had the same meeting place);
- 7) Sessions prior to discharge (indicating the average of how many groups a patient attended prior to discharge);
- 8) Groups disturbed (indicating whether groups were disturbed while in progress);
- 9) Open versus time limited (indicating whether groups are conducted continuously over time or for a specified number of sessions, i.e., a total of five sessions and the group is terminated);
- 10) Length of session;

- 11) Theory (indicating the number of group therapy theories practiced and which theory was the most frequently used, in this case, Cognitive-behavioral);
- 12) Program designer (indicating who designed the group therapy program);
- 13) Types of groups (indicating how many different types of groups were offered and which type was the most frequently offered, in this case, Cognitive-behavioral);
- 14) Therapist training; and
- 15) Desirable factors (indicating the factors described by the practitioners as being desirable for providing effective group therapy).

Several items on the Group Therapy Practitioner Protocol were not evaluated relative to unit size. These items were the Providers of Group Therapy, the Group Pentagon Components section, Obstacles to Effective Group Therapy, Third Party Influencing, Principal Challenges, and Future Group Therapy Viability.

Across the variables, there was very little difference between the sizes of units. Of the 15 variables monitored, there was no difference in unit sizes on seven variables. Differences were very minimal on seven other variables. The only major difference relating to unit size was in the types of groups offered on the units. Smaller units offered 52 different types of groups while larger units offered 65 different types of groups. As previously noted, this difference is probably due to larger units requiring a greater diversity in group offerings because of a greater diversity of patient symptoms and problems. On this item, though, both larger and smaller indicated cognitive behavioral groups were rank ordered first in frequency. In summary, there was no appreciable difference in response for smaller and larger units.

Synthesis of the Data

Many results of this study stand alone in their significance to current practices and trends in General Hospital Group Therapy (i.e., average length of stay, average daily census, or average number of beds per unit). Combining various responses more fully explores the results of this study. This section synthesizes data from different parts of the survey and the interviews into three categories:

- 1) patients;
- 2) therapists; and
- 3) nature of group therapy.

Summarizing statements supported by a description and an explanation of the different factors combined are made under each category.

Patients

Statement 1: When combining Average Length of Stay, Group Attendance, Length of Sessions, Number of Groups Attended Prior to Discharge, and Patient Exclusion from Group Therapy, group therapy comprised a major and important portion of a patient's treatment. A patient stays on the average 6.5 days in the hospital and is exposed, on the average, to 3.75

groups per day or 24.42 groups during that stay. The median length of session is one hour. These group therapy sessions therefore comprise almost four hours of treatment per day. Two thirds of the units do not exclude any patients and report no exclusion criteria while two thirds mandated that all patients attend all groups. Patients therefore:

- a) stay in the hospital a short time;
- b) are required to attend at least three group sessions per day; which
- c) total almost four hours of group therapy per day.

Statement 2: When combining Diagnosis and Average Length of Stay, patients were experiencing acute episodes of mental illness or debilitating emotional disturbance but received brief periods of inpatient treatment. The three most frequently listed diagnoses were Depression, Bipolar Affective disorder, and Schizophrenia. Combined with Psychoses and Dementia, these five categories represent 87 percent of all diagnoses. Further, the Average length of stay is 6.5 days. Therefore, a significantly impaired patient is admitted to an inpatient unit where treatment will last a short period of time before the patient is discharged from the hospital.

Statement 3: When combining Group Attendance, Patient Exclusion from Group Therapy, Number of Groups Attended Prior to Discharge, Types of Groups, Patient Assignment to Specific Groups, and Group Pentagon Components, patients were expected and scheduled to attend almost four hours of group therapy per day covering a variety of topics and techniques which may not be related to the patients' own symptoms or goals. Two thirds of the units require group attendance while two thirds do not exclude any patients from any groups. Thirty-seven different types of groups were offered by six units representing a variety of topics and techniques.

Additionally, administrators reported 42 percent of the units assigned patients to groups either by assigning all patients to all groups or the units had no criteria for this process. Five of the six practitioners interviewed indicated patients were assigned to groups without regard to specific patient symptoms or problems, and two thirds of the practitioners reported that no patient goals were set for each group. Finally, 83 percent of the practitioners indicated no group goals are set for each group. Consequently, patients spent a sizable amount of time in a therapeutic activity that was not directly based on their own behaviors, problems, or goals.

Therapists

Statement 4: When combining Group Therapist Training, Delineation and Presence of Desirable Factors, Obstacles to Effective Group Therapy, and Group Therapy Future Viability, group therapy practitioners recognized the importance of, yet current lack of, and need for training and education for general hospital group therapists. Eighty-three percent of the practitioners cited "Well trained staff" as a desirable factor for effective group therapy yet 83 percent also reported that this factor was not present in their operation. Additionally, 83 percent of the practitioners indicated "Undertrained staff" was the major challenge in providing effective group therapy. Two thirds of the practitioners also noted that "Well trained staff" was one of the two primary factors that would ensure group therapy viability into the future. Yet, the

practitioners' training revealed little academic instruction and relied heavily on on-the-job training that was generally unstructured and unsupervised. Consequently, these results illustrate an acute need for additional training for general hospital group therapists.

Statement 5: When combining Providers of Group Therapy, Group Therapist Characteristics, Professional Staffing, Delineation and Presence of Desirable Factors, considering all professions (i.e., Counseling, Social Work, etc.) general hospital group therapy was provided by staff with limited education, training, and experience in group therapy techniques. The Nursing profession comprised 70 percent of the staff on the units and 65 percent of the total providers of group therapy while possessing the lowest educational and experience levels of all professions. The practitioners (83 percent) recognized their units lacked the presence of "Well trained staff". Consequently, the majority of group therapy provided on these units was provided by staff with limited training, education, and experience.

Statement 6: When combining Diagnosis, Training of Group Therapists, Number of Sessions Attended Prior to Discharge, Obstacles to Effective Group Therapy, and Group Attendance, group therapists with limited training and education provided an important aspect of treatment to a clinically diverse and challenging population. Five categories representing 87 percent of all patient diagnoses reflected potentially debilitating mental illnesses or emotional disturbances. Sixty-seven percent of the units required patients to attend up to four hours of group therapy per day, seven days per week.

The majority of this group therapy was provided by staff with limited education, training, and experience, and when the more educated, more trained, more experienced staff provided the group therapy, even their specific group therapy training was limited. Five of the six practitioners reported "Undertrained staff" as the primary challenge in providing effective group therapy. Thus, the group therapy process was highly utilized with potentially severely compromised patients but was provided by therapists with limited education and training.

Nature of Group Therapy

Statement 7: When combining Group Pentagon Components, Diagnosis, Patient Assignment to Groups, Group Attendance, Who Establishes Patient Group Goals, and Patient Exclusion from Group Therapy, group therapy was provided to patients without discriminating between individual patient problems or goals. Two thirds of the practitioners indicated group attendance is mandatory for all patients while two thirds of the units do not exclude any patients from groups. A diffuse number of diagnostic categories were encountered on the units. Forty two percent of the of the responses describing patient assignment to groups indicated there are either no criteria used for assignment or all patients attend all groups. Forty four percent of the units reported no goals for each patient for each group were set. Five of the six group therapy practitioners reported all patients attend all groups without regard to specific patient problems or goals, and patient and group goals for each group were not established. Consequently, patients exhibiting a variety of symptoms or problems were treated in group therapy without specific planning of the groups to treat those problems or symptoms.

Statement 8: Combining Diagnosis, Group Attendance, Group Pentagon Components, Factors Determining Group Therapy Techniques, and Primary Factor Determining Group Therapy Techniques, group therapy techniques to treat a variety of patient problems or symptoms were chosen without discriminating between those patient symptoms or problems and were based primarily on therapist familiarity and expertise with the methods. Two thirds of the practitioners noted group attendance was mandatory for all patients. As determined by diagnosis, a diverse and challenging patient population was treated on the units. Across the units, thirty one percent of all methods utilized to determine which group therapy techniques were used was “Therapist familiarity and expertise with the techniques”, while 18 percent of these units indicated this was the only factor used in determining which techniques would be used in a group. Further, fifty percent of the units reported the primary factor in determining which techniques were used in a group was “therapist familiarity and expertise with the techniques.”

All six practitioners noted groups were scheduled typically one week in advance and this schedule may be used months at a time. Only one of the practitioners reported that methods to be used in a group were also based on patient problems or goals at the time of the group. As a result, in group therapy a variety of patient problems and goals were encountered but techniques used in these groups were chosen based not on the problems or goals but on therapist expertise and familiarity with the group techniques.

Statement 9: When combining Assessment of Patient Behavioral Changes for Each Group, Group Therapy Program Evaluation, and Group Pentagon Components, evaluation of the group therapy process and program was limited. On 39 percent of the units, no evaluation of patient change per group was performed, 33 percent of all programs were not evaluated, and of the 67 percent of the units undergoing some evaluation, that evaluation was conducted by a variety of individuals indicating no consistency of evaluators across units. The six practitioners reported of 18 possible evaluation areas for the group therapy process and program on their units, only one evaluation was regularly performed. Hence, evaluation of group therapy and group therapy programs was limited.

Statement 10: When combining Delineation and Presence of Desirable Factors, Principal Challenges, Group Therapy Future Viability, Responder Titles, Patient Assignment to Specific Groups, Who Establishes Patient Group Goals, Benefits/Risks/Consequences Explained to Patient, and Group Pentagon Components, group therapy programs were not designed, implemented, or evaluated in a consistent, effective manner and a workable model is needed. There is notable variance in how units assign patients to group therapy, and 44 percent of the units set no goals for each patient for each group and when patient goals for each patient for each group are set, there is no consistency across units in how this is accomplished. Fifty percent of the units report no explanation was provided to patients relative to the potential outcomes of their participation in group therapy and when explanations were provided, they were usually not documented. There were even diverse titles for the administrators of the units.

As reported by the practitioners, patients were assigned to groups without regard to patient problems or symptoms, goals for patients or groups were usually not set, groups were planned at least one week in advance and methods used were based not on patient symptoms or

goals but on therapist expertise and familiarity with techniques, risks or benefits of group therapy were not explained to patients, and group processes and programs were not evaluated. The practitioners cited the lack of a workable model to conduct such procedures.

Finally, 71 percent of those factors identified by the practitioners as desirable for effective group therapy were reported as not being present on the units. They identified the development of effective models of group therapy as a challenge for the survival of general hospital group therapy into the future and that workable models of group treatment and documentation were vital for group therapy future viability.

When taken together, the above evidence suggests a need for the design and implementation of an effective model of group therapy.

Statement 11: When combining Group Punctuality, Disturbing of Groups, Group Therapy Program Evaluation, Delineation and Presence of Desirable Factors, Obstacles to Effective Group Therapy, and Group Therapy Future Viability, group therapy programs were implemented as an integral component of treatment but actually played a vague role in treatment. Group therapy did not begin and end on time, according to four of six of the practitioners. All six practitioners indicated the disturbing of groups had been or was currently a serious problem on the units. The punctuality and disturbance issues sometimes resulted in groups being canceled or terminated early. One third of the units reported there was no group therapy program evaluation and five of the six practitioners noted there was no formal process for evaluating the group therapy programs.

Five of the six practitioners also stated, “No distractions or interruptions” was a desirable factor for effective group therapy yet five of six reported this desirable factor was not present in their operation. Also, two of the six practitioners noted, “Patients and groups being on time” was a desirable factor for effective group therapy. When describing obstacles to effective group therapy, 67 percent claimed “Distractions and interruptions” was a serious problem on their units. Indeed, half of the practitioners suggested the survival of general hospital group therapy was dependent on group therapy being, “Accepted as a valuable component of treatment”, and alluded that group therapy had been reduced to a “babysitting” service.

Clearly, group therapy played a frequent role in general hospital treatment programs but there was strong evidence that it was not respected as a valuable tool of treatment.

Statement 12: When combining Providers of Group Therapy, Practitioner Training, Types of Groups, Components of Group Therapy, Delineation and Presence of Desirable Factors, and Factors Determining Group Therapy Techniques, group therapy on general hospital psychiatric units has become a vague term provided by practitioners from a variety of professions with limited training, utilizing vague procedures for determining methods to be used in groups and vague or no methods for evaluating groups and group therapy programs. Group therapy was provided by professionals from five different professions and varying, often very limited, educational and experiential levels. Group therapist training was minimal and frequently was based on unstructured, unsupervised on-the-job training.

The determination of methods to be used in each group was based primarily on “Therapist familiarity and expertise with the group therapy techniques” and not directly related

to patient's problems or goals. Group therapy program evaluation was usually not done at all. Practitioners reported their units function without the presence of many of the factors which they believe desirable for effective group therapy. Thus, the group therapy concept appeared vague in its design, implementation, and evaluation, and was provided by varying professions with limited or no training in group therapy.

Summary

The following results are a synthesis of data from the survey and the interviews:

- 1) Group therapy comprised a major and important portion of a patient's treatment;
- 2) Patients were diagnosed with acute episodes of mental illness or debilitating emotional disturbance but received brief periods of inpatient treatment;
- 3) Patients were expected and scheduled to attend almost four hours of group therapy per day covering a variety of topics and techniques which may not be related to the patients' own symptoms or goals;
- 4) Group therapy practitioners recognized the importance of, yet current lack of, and need for training and education for general hospital group therapists;
- 5) When considering all professions, general hospital group therapy was provided by staff with limited education, training, and experience in group therapy techniques;
- 6) Group therapists with limited education and training provided an important aspect of treatment to a clinically diverse and challenging population;
- 7) Group therapy was provided to patients without discriminating between individual patient problems or goals;
- 8) Group therapy techniques to treat a variety of patient problems or symptoms were chosen without discriminating between those patient symptoms or problems and were based primarily on therapist familiarity and expertise with the methods;
- 9) Evaluation of the group therapy process and program was limited;
- 10) Group therapy programs were not designed, implemented, or evaluated in a consistent, effective manner and a workable model is needed;
- 11) Group therapy programs were implemented as an integral component of treatment but actually played a vague role in treatment; and
- 12) Group therapy on general hospital psychiatric units has become a vague term provided by professionals from a variety of professions with limited training, utilizing vague procedures for determining methods to be used in groups and vague or no methods for evaluating groups and group therapy programs.

Summary

This chapter has reviewed the results of this study. The first section described response rates to the surveys. The second and third sections presented data pertaining to the General Hospital Psychiatric Unit Survey and the Group Therapy Practitioner Interviews, respectively.

The third section organized data pertaining to large versus small units. The final section presented a synthesis of the data.

CHAPTER FIVE

Discussion

Introduction

This chapter provides a summary of the study, reviewing the results for each Research Question; conclusions; discussion; and implications and recommendations for future research. An anecdotal note concludes the Chapter.

Summary

This study evaluated the current practice of general hospital group therapy and determined whether there was a need for a more systematic method of designing, implementing, and evaluating general hospital group therapy. After summarizing national statistics on general hospital psychiatric units, this study focused on reviewing operational statistics, staffing patterns, types of patients, and group therapy practices on general hospital psychiatric units by administering a survey to general hospital psychiatric unit administrators in a southeastern state. To gather information related to specific group therapy practices, to evaluate whether Group Pentagon components were utilized in group therapy practices, and to identify factors influencing group therapy practices, interviews were conducted on-site with six group therapy practitioners, one each from the three largest and three smallest units responding to the first survey.

This study addressed five research questions. Major results are summarized below.

1. What is the developmental history of inpatient group therapy to date?
Inpatient group therapy has a seventy-five year formal history of development, greatly influenced by outpatient group therapy practices. Since the late 1970's, inpatient group therapy has gained recognition as a treatment modality different and separate from outpatient group therapy. Group therapy was initially based on medical models of treatment, but practitioners, in the past twenty years, have turned to more interpersonal approaches. Group therapy techniques have increased dramatically during this twenty year period. Responding to myriad influences, inpatient group therapy is now experiencing significant change.
2. What are the available statistical data relevant to general hospital psychiatric units?
On the national level, statistical data was sparse. Information regarding unit operations was limited and information regarding group therapy practices, if available, was not found. Assessed by the General Hospital Psychiatric Unit Survey, variances in unit characteristics such as size, length of stay, types of groups offered, staffing patterns, and types of patients were described.
3. What are the current group therapy practices in general hospital psychiatric units?
There is little information from the available literature collectively describing group therapy practices on general hospital psychiatric units. General hospital group therapy is usually described as part of inpatient group therapy which may include a

variety of inpatient settings such as private psychiatric hospitals or Veteran Administration psychiatric units and hospitals. While some aspects of group therapy practices were similar across units (such as number of patients per group and length of group therapy sessions), inpatient group therapy practices were generally variable from unit to unit and programs appeared to be inconsistent in designing, implementing, and evaluating group therapy.

The General Hospital Psychiatric Unit Survey and the Group Therapy Practitioner Interviews specifically summarized group therapy practices on general hospital psychiatric units in a southeastern state. Group therapy programs varied across units and did not appear to be designed, implemented, or evaluated in a consistent manner. Indeed, these group therapy programs appeared fragmented and vague in their conception and implementation while not addressing evaluation of either group outcomes or group programs.

4. To what extent are the components of the Group Pentagon utilized in general hospital group therapy?

Information across the literature was also very limited regarding if and how the elements of the Group Pentagon were utilized in general hospital group therapy. Combining the results of the General Hospital Psychiatric Unit Survey, the Group Therapy Practitioner Interviews, and the available literature, it appears group therapy programs do not have a consistent process for assigning patients to groups, do not design patient group goals or specific group goals for each group, do not utilize methods based on specific patient goals for each group, do not explain risks or consequences of group therapy to patients, and exercise very limited evaluation of patient progress in groups or of overall group therapy programs. Consequently, the components of the Group Pentagon are not utilized in the general hospital group therapy in this study.

5. What are the desirable components of group therapy as identified by practitioners of general hospital group therapy?

The Group Therapy Practitioner Interviews addressed, during on-site interviews, the opinions of practitioners as to those conditions they deem desirable for providing effective general hospital group therapy as well as those factors which they believe are significantly influencing the provision of general hospital group therapy. Respect and support for the group therapy process, the need for adequately trained staff, and an effective model for the design and provision of group therapy programs were conditions cited as necessary for effective group therapy. Importantly, many conditions the practitioners indicated were necessary for effective group therapy were not evident in their operations. The lack of time and the absence of a model to design and document group therapy were noted by the practitioners as critical problems.

Conclusions

Conclusion 1: Group therapy comprised a major and important portion of a patient's treatment. The data indicated that while a patient's average stay in the hospital was less than one week, the patient was exposed to up to four groups per day. The data, including statements from group therapy practitioners, also indicated that patients were highly encouraged to attend groups. These results coincide with Yalom (1983, 1993), and Brabender and Fallon (1993) that group therapy was an important treatment component in inpatient psychiatric treatment. Zimpfer (1984) also noted group therapy provided the basis for treating the most people, in the shortest time possible, with the fewest therapists. If the patient is going to be in the hospital for only a short period of time and the hospital wants to utilize the fewest resources to provide maximum treatment, it stands to reason that group therapy is the best choice to provide that maximum treatment. That it will continue to be an important element of inpatient psychiatric treatment was noted by Spitz (1996). That it will be an important element of general hospital psychiatric treatment was noted by the practitioners surveyed in this study.

Conclusion 2: Patients were experiencing acute episodes of mental illness or emotional disturbance but received brief periods of inpatient treatment. Beck (1994), Feldman and Fitzpatrick (1992), and Goodman, Brown, and Deitz (1992) all allude to the impact of managed care and other forces in today's healthcare resulting in more brief and financially monitored or controlled treatment. The results indicated patients admitted for treatment were experiencing significant psychiatric impairment but were treated on the average less than seven days before being discharged from the hospital. This trend of briefer inpatient treatment was recognized by the practitioners surveyed in this study and will continue.

Conclusion 3: Patients were expected and scheduled to attend almost four hours of group therapy per day covering a variety of topics and techniques which may not be related to the patients' own symptoms or goals. That group therapy is an important and frequent aspect of inpatient has been established in Conclusion 1. Yalom (1983, 1995) noted group therapy programs must be sensitive to specific needs of specific types of patients. Yet, Farley (1996) noted patients were assigned to group therapies without discriminating for a patient's symptoms, problems, or goals. This pilot data was confirmed by the major research. The administrators and group therapy practitioners surveyed in this study asserted patients were assigned to groups irrespective of the patient's symptoms, problems, or goals. They noted groups were usually scheduled at least one week in advance and the same groups may be repeated week after week. The prevailing opinion was that groups were planned and conducted based on the group therapists' familiarity and expertise with certain techniques, and not on the goals for a patient.

Conclusion 4: Group therapy practitioners recognized the importance of, yet current lack of, and need for training and education for general hospital group therapists. Across the literature information on general hospital group therapy has been noted to be sparse. Literature regarding the training and education of group therapists working in general hospital psychiatric programs is very limited.

Group therapy practitioners surveyed in this study repeatedly cited the need for adequately trained staff. Training, even for experienced therapists, was limited. Worse, group therapy is now being conducted by providers without academic backgrounds in group therapy or supervised on-the-job training. The practitioners noted that even for those group therapists with academic instruction in group therapy, inpatient psychiatric units were frequently used as training grounds for therapists or for obtaining licensure before moving on to other positions. Group therapy, once the province only of psychiatrists and psychologists, is now being conducted by practitioners from numerous professions with limited education and training in group therapy.

Conclusion 5: When considering all professions (i.e., Counseling, Social Work, Nursing, etc.) general hospital group therapy was most typically provided by staff with limited education, training, and experience in group therapy techniques. Nursing has become the primary profession for the provision of group therapy on general hospital psychiatric units. Most RN's and LPN's have one or two years academic preparation involving minimal psychiatric instruction.

Even staff with some academic instruction in group therapy rarely have had more than two classes. On- the-job supervision was described by the practitioners in this study as minimal and unstructured. The practitioners indicated that psychoeducational groups were used most frequently. Process and interactional groups were additionally described as being offered much less often than the psychoeducational groups. Psychoeducational groups tend to be more structured and didactic in their methods, a fact that appeals to providers without the knowledge and skills necessary to adequately conduct process or interactional groups.

Conclusion 6: Group therapists with limited training and education provided an important aspect of treatment to a clinically diverse and challenging population. That patients admitted for psychiatric treatment are experiencing major dysfunction is supported by the administrators and practitioners surveyed in this study. Kapur, Ramage, and Walker (1986), and Brabender (1993), noted the emergence of more clinically diverse and difficult patient populations. Conclusions 4 and 5 indicated those doing group therapy had very limited education and training. Consequently, perhaps the most difficult and challenging patient populations that should be treated by the most educated, highest trained therapists are actually treated by the least trained group therapists among all professionals providing group therapy in this treatment setting. This patient population calls for the most adequately trained therapists, not the least.

Conclusion 7: Group therapy was provided to patients without discriminating between individual patient problems or goals. Corey and Corey (1992) note the importance of setting relevant and specific treatment goals. That patients were assigned to groups in this study irrespective of individual patient symptoms, problems, or goals was discussed in Conclusion 3. When combined with Conclusion 6 that patients are treated by the least trained therapists, the result is even more alarming. Group therapy is not directed toward individual patient problems, and it is provided by therapists with limited training in group therapy techniques.

Conclusion 8: Group therapy techniques to treat a variety of patient problems or symptoms were chosen without discriminating between those patient problems or symptoms and were based primarily on therapist familiarity and expertise with the methods. The diverse and challenging patient population was discussed in Conclusion 6. The administrators and practitioners surveyed in this study acknowledged group therapy methods chosen for each group were not based on specific patient problems, symptoms, or goals but were primarily based on a therapist's familiarity and expertise with those techniques chosen for that group. The Farley (1996) study also found group methods to be based on therapist familiarity and expertise with the methods. Yalom (1983, 1995) indicated "decisions about numbers, types, and frequencies of groups were often made on the basis of what will not ruffle the staff rather than of what will be most effective for the patient." Brabender (1993) noted significant variance among units in the establishment of goals for treatment and in the choice of methods used in groups.

Consequently, not only is group therapy provided to difficult and diverse populations by inadequately trained staff, it is also provided without discriminating between patient symptoms or problems, and methods used in the groups are not based on patients' goals, problems, or symptoms, but on the group therapist's familiarity and expertise with the methods.

Conclusion 9: Evaluation of the group therapy process and program was limited. Administrators and practitioners surveyed in this study noted evaluation of patient progress in the group, the group process, and group therapy programs were very limited. The Farley (1996) study found similar results. An analysis of the available literature also revealed the lack of any evaluation procedures. Brabender (1993), Hamilton, Travis, Richmond, Hanson, Swanson, and Stafford (1993), and Brabender and Fallon (1993) cite the importance and necessity of evaluation of inpatient group therapy, yet this does not appear to be occurring.

Combining Conclusions 4,5,6,7, and 8, clinically difficult patient populations are being treated by inadequately educated and trained staff who provide group therapy without discriminating for individual patient problems, symptoms, and goals; they utilized group methods not based on patient problems or goals; and they conducted minimal evaluation of patient progress, the group process, or the overall group program.

Conclusion 10: Group therapy programs were not designed, implemented, or evaluated in a consistent, effective manner and a workable model is needed. Combining Conclusions 4,5,6,7,8, and 9 with the available literature, the lack of a model for general hospital group therapy programs appears obvious. Group therapy programs appear fragmented in their design and they are not evaluated. The Farley (1996) study results were consistent with this study. Brabender (1993) noted there did not appear to be a consistent method of designing, implementing, and evaluating group therapy programs. Group practitioners in this study cited the need for a model to more effectively provide general hospital group therapy that addresses time constraints as well as documentation issues. Thus, the lack of an effective, workable model is apparent.

Conclusion 11: Group therapy programs were implemented as an integral component of treatment but actually played a vague role in treatment. The important role of group therapy on general hospital psychiatric units was discussed in Conclusions 1 and 3. Yet, the administrators

and practitioners surveyed in this study noted severe problems related to group punctuality and disturbances during group therapy sessions. Half of the practitioners cited group therapy being accepted as a valuable component of treatment as being necessary for the survival of general hospital group therapy. Yalom (1983, 1995) noted methods for recognizing skepticism and pessimism about group therapy:

- 1) group meetings are interrupted;
- 2) groups are canceled or terminated early;
- 3) groups are led by untrained or unskilled staff;
- 4) groups are considered to be time fillers; and
- 5) groups have a variety of functions.

All five criteria for recognizing group skepticism noted by Yalom were complaints issued by the group practitioners surveyed in this study.

Conclusion 12: Group therapy on general hospital psychiatric units has become a vague term provided by a variety of professionals with limited training utilizing a variety of procedures for determining methods to be used in groups and vague or nonexistent methods for evaluating groups and group therapy programs. Combining Conclusions 1-11 results in concluding that general hospital psychiatric units have significant deficits in the provision of group therapy. Consistent with the results of the Farley (1996) study, these significant deficits are recognized by the practitioners surveyed in this study and represent a major obstacle to the future viability of general hospital psychiatric unit group therapy programs.

Discussion

The purpose of this study as stated in Chapter One was twofold:

- 1) to evaluate the current practice of group therapy in general hospital psychiatric units in a southeastern state and to determine whether there was a need for a more systematic method of designing, implementing, and evaluating general hospital group therapy; and
- 2) to test a model that could be used to evaluate current practices of general hospital psychiatric unit group therapy on a more global basis.

The Conclusions of this study address the purposes of the study in the following manner:

- 1) Is there a need for a more systematic method of designing, implementing, and evaluating general hospital group therapy?

Without question this study has demonstrated a need for the development of a model to provide a systematic method of designing, implementing, and evaluating general hospital group therapy. From the lack of information in the literature about general hospital group therapy, to concerns in the literature expressed about the practice of inpatient group therapy, to concerns expressed in this study by administrators of group therapy programs, to concerns expressed in this study by practitioners of general hospital group therapy, there are apparently serious deficits in the effective operation of group therapy programs and there does not appear to be a workable model for group therapy practitioners.

Current model deficits appear in many areas including:

- a) the assignment of patients to groups;
- b) the development of group goals and patient group goals;
- c) the methods for determination of group techniques for each group;
- d) explanation of risks or consequences of group therapy to the patient;
- e) the evaluation of individual patient progress in groups, of group progress toward group goals, and of overall group therapy programs; and
- f) documentation requirements.

The development of such a workable model transcends what theory and techniques a therapist or program may utilize. Rather, such a model would establish the process for effectively utilizing whatever techniques the therapist or program would espouse to provide the patient the most individualized, effective group treatment possible.

- 2) Does this study provide a model or protocol for evaluating current practices of general hospital psychiatric unit group therapy on a more global basis?

This survey study establishes a foundation for the evaluation of general hospital psychiatric unit group therapy either on a larger geographical basis or of inpatient group therapy in different treatment settings. Combining information from administrators and practitioners provided a more complete picture of a unit and its group therapy operations than if the study had focused on either one alone.

Practitioner interviews utilized in the design of this study were a major source of information but, on a larger scale, could present practical problems such as travel time and expenses.

More specifically, the components of the Group Pentagon provided a practical and comprehensible model for organizing information about the overall design of group therapy programs (e.g., how patients are assigned to groups, if and how goals are set for a patient per group, or if and how group goals are set). Further, utilizing the Group Pentagon components to evaluate specific group therapy practices proved to provide relevant information about how groups are conducted while being easily understood by administrators and practitioners.

Implications and Recommendations

This research has clearly demonstrated several major general facts:

- 1) group therapy is an integral, important aspect of general hospital psychiatric treatment;
- 2) many people are treated each year with general hospital psychiatric unit group therapy;
- 3) the forces influencing the practice of general hospital psychiatric unit group therapy are dynamic and significant;
- 4) the concept of general hospital psychiatric unit group therapy is changing; and
- 5) there are many limitations in the design, implementation, and evaluation of general hospital group therapy programs.

Accompanying these facts are the following implications and recommendations:

- 1) Employers, hospitals, and practitioners need to recognize the current and future importance of group therapy as vital, revenue producing components of general hospital group therapy programs. Group therapy on general hospital psychiatric units should be recognized as being as vital to treatment as physical therapy is to rebuilding bodies. To respect this modality as a viable treatment modality, procedures to ensure its effective provision must be developed and implemented.
- 2) There is inadequate education or training for general hospital group therapy practitioners. Nursing, Counselor, Social Work, Recreational Therapy, Occupational Therapy, and Psychology academic programs need to recognize their graduates may provide some type of group therapy services if employed in hospitals. As part of their curriculum, these academic programs should provide instruction in group theory and technique. Internship programs should ensure adequate supervision and training in group therapy activities. Employers (hospitals) should recruit practitioners experienced in group therapy and attempt to continue the employment of experienced group therapists. Inservice training, on-the-job training, and adequate supervision of group therapists should be ensured by hospital and program administrators.
This study does not criticize any particular profession. Rather, the study clearly indicates that education and training for all professionals reflected in this study as providing group therapy services in general hospitals may be inadequate and there is a need to ensure adequate instruction in group theory and technique for all practitioners.
Training in the creation of goals, treatment planning, group techniques, and measuring outcomes is essential to effectively confront treatment accountability issues from managed care and government gatekeeper programs.
- 3) This study should be replicated using a larger sample from a broader geographical area.
- 4) Other criteria such as the role and effect of psychoactive medications on participants in group therapy need to be evaluated.
- 5) Outcome measures need to be developed to evaluate patient progress, group progress toward group goals, and overall group therapy programs. These measures play a vital role in defining and evaluating group therapy programs and practices.
- 6) There is a critical need, as defined by this study, for a workable model to provide a logical, effective group therapy treatment program. The Group Pentagon was developed to provide a pragmatic tool to design, implement, and evaluate group therapies. In this study, the Group Pentagon provided a useful format for evaluating overall group therapy programs as well as specific group therapy procedures. Therefore, research is recommended to evaluate the effectiveness of the Group

Pentagon as a model for designing and implementing group therapy programs in general hospital psychiatric units.

- 7) Replication studies and future research should include patient input and information regarding group therapy strengths, weaknesses, and effectiveness.

Anecdotal Note

As this study was conducted, the researcher had an opportunity to observe facets of the provision of group therapy on general hospital psychiatric units that were either not a focus of the research or not directly supported by data. These observations may be useful in future similar research.

1) There appears to be a great deal of group activity on these units that may not actually be group therapy. The definition of “group therapy” on general hospital psychiatric units may no longer conform to traditional definitions of group therapy. Consequently, future studies may need to address this possible conceptual change to ensure accurate measurement of “group therapy.”

2) Clinical and administrative staff on these units work in an atmosphere of increased pressure from hospital administrations and owners to enhance revenue and profit while reducing expenditures and improving quality. Additionally, the rapid growth and influence of managed care into behavioral healthcare services has further created an atmosphere of confusion and turmoil regarding the entire treatment process. As a result, the psychiatric unit staff actually perform extremely well in the face of such pressures, in this researcher’s opinion. Further research involving staff or therapeutic procedures on these units should address the impact of these forces.

3) As a result of the pressures described above, staff on general hospital psychiatric units experience limitations including:

- a) decreased number of staff to provide the same or in some cases, increased activities resulting potentially in diminished quality of service;
- b) increased documentation to the point where at times, it takes longer to document a procedure than it does to provide it;
- c) severe time constraints relative to increased activity and documentation;
- d) decreased availability of funding for patient care resources such as educational materials and films; and
- e) decreased funding for education and training of staff.

Further studies must consider the impact of these limitations on research variables or perhaps address these limitations as research variables.

REFERENCES

- Alonso, A., and Rutan, J. (1984). The impact of object-relations on psychodynamic group therapy. International Journal of Group Psychotherapy, 141(11), 1376-1380.
- Ashback, C., and Schermer, V. (1987). Object relations and the self, and the group: a conceptual paradigm. London: Routledge and Kegan Paul.
- Beck, A. (1991). Cognitive therapy: a 30 year retrospective. American Psychologist, 46(4), 368-375.
- Beck, M. (1994). Managing the mind (managed care of psychological services). Newsweek, 123(23), 30-32.
- Beeber, A. (1991). Psychotherapy with schizophrenics in team groups: a systems model. American Journal of Psychotherapy, 45(1), 78-87.
- Brabender, V. (1985). Time limited inpatient group psychotherapy: a developmental model. International Journal of Group Psychotherapy, 35(3), 373-390.
- Brabender, V. (1993). Inpatient group psychotherapy. In Comprehensive Group Psychotherapy, Kaplan, H., Saddock, B., editors, p 607. Baltimore, Md.: Williams & Wilkins.
- Brabender, V., and Fallon, A. (1993). Models of inpatient group psychotherapy. Washington, DC: American Psychological Association.
- Brand, E., and Clingepeel, W. (1992). Group behavioral therapy with depressed geriatric patients: an assessment of incremental efficacy. Behavior Therapy, 23, 475-482.
- Cohn, B. 1994 (1994). Recycling Yalom: using a systems analysis to facilitate work in inpatient groups. Group Analysis, 27(4), 407-418.
- Corey, G., and Corey, M.S. (1992). Group process and practice. Pacific Grove, CA: Brooks Cole.
- Erickson, R. (1984). Inpatient small group psychotherapy. Springfield, IL: Charles C. Thomas.
- Farley, P. (1996). Pilot study of inpatient group therapy. Unpublished manuscript. Virginia Polytechnic Institute and State University.
- Feldman, J. and Fitzpatrick, R., (eds)(1992). Managed mental health care: administrative and clinical issues. Washington, DC: American Psychiatric Press.
- Flowers, J. (1979). Behavioral analysis of group therapy and a model for behavioral group therapy. In Behavioral group therapy 1979: an annual review, Upper, D., and Ross, S. (eds), 5-37. Champaign, IL: Research Press.
- Foulkes, S. (1948). Introduction to group-analytic psychotherapy: studies in the social integration of individuals and groups. London: Heinemann.
- Frank, J. (1963). Group therapy in the mental hospital. In Group psychotherapy and group function, Rosenbaum, M. and Berger, M. (eds), 453-468. New York: Basic Books.
- Goodman, M., Brown, J., and Deitz, P. (1992). Managing managed care: a mental health practitioners survival guide. Washington, DC: American Psychiatric Press.
- Hamilton, J., Travis, C., Richman, B., Hanson, P., Swanson, C., and Stafford, J. (1993). Quality assessment and improvement in group psychotherapy. American Journal of Psychiatry, 150(2), 316-321.

Hannah, S. (1984). Counter transference in inpatient group psychotherapy: implications for techniques. International Journal of Group Psychotherapy, 34(2), 257-272.

Herz, M. (1979). Short-term hospitalization and the medical model. Hospital and Community Psychiatry, 30, 117-121.

Hutchins, D.E. (1993). Designing effective groups. Unpublished manuscript. Virginia Polytechnic Institute and State University.

Kahn, E., Webster, P., and Storck, M. (1986). Curative factors in two types of inpatient psychotherapy groups. International Journal of Group Psychotherapy, 36(4), 579-585.

Kapur, R., Ramage, J., and Walker, K. (1986). Group psychotherapy in an acute patient setting. Psychiatry, 49(4), 337-349.

Kibel, H. (1989). A historical memoir on group psychotherapy. In Group psychodynamics: new paradigms and new perspectives, Halperin, D. (ed), 3-28. Chicago, IL: Year Book Medical.

Kibel, H. (1992). Diversity in the practice of inpatient group psychotherapy in North America. Group Analysis, 25 (2), 225-245.

Kibel, H. (1993). Less time to do more-psychotherapy on the short term inpatient unit. Washington D.C.: American Psychiatric Press.

Kiesler, C., and Simpkins, C. (1991). The de facto national system of psychiatric inpatient care: piecing together a national puzzle. American Psychologist, 46, 579.

Klein, R. (1977). Inpatient group psychotherapy: practical considerations and special problems. International Journal of Group Psychotherapy, 27, 201-214.

Lazell, E. (1921). The group treatment of dementia praecox. Psychoanalytic Review, 8, 168-179.

Lieb, R., and Thompson, T. (1984). Inpatient group treatment of anorexia nervosa. International Journal of Group Psychotherapy, 34(4), 639-642.

MacKenzie, R. (1990). Introduction to time limited group psychotherapy. Washington, D.C.: American Psychiatric Press.

Main, T. (1946). The hospital as a therapeutic institution. Bulletin of the Menninger Clinic, 10, 66-70.

Manderscheid, R., and Sonnenschein, M. (1994). Mental Health, United States, 1994. Washington, DC: Department of Health and Human Resources, Superintendent of Documents.

Marcovitz, R., and Smith, J. (1986). Short term group therapy: a review of the literature. International Journal of Short-Term Psychotherapy, 1, 49-57.

Marsh, L. (1931). Group treatment by the psychological equivalent of the revival. Mental Hygiene, 15, 328-349.

Maves, P. and Schultz, J. (1985). Inpatient group treatment on short-term acute care units. Hospital and Community Psychiatry, 36(1), 69-72.

Maxmen, J. (1984). Helping patients survive theories: the practice of an educative model. International Journal of Group Psychotherapy, 34(3), 355-368.

Oldham, J., and Russakoff, L. (1987). Dynamic therapy in brief hospitalization. Northvale, NJ: Jason Aronson.

Parloff, M. and Dies, R. (1977). Group psychotherapy outcome research: 1966-1975. International Journal of Group Psychotherapy, 27(3), 281-319.

Pam, A., and Kemker, S. (1993). The captive group: guidelines for group therapists in the inpatient group setting. International Journal of Group Psychotherapy, 43(4), 419-438.

Powdermaker, F., and Frank, J. (1953). Group psychotherapy: studies in methodology of research and therapy. Cambridge, MA: Howard University Press.

Redick, R., Witkin, M., Atay, J., and Manderscheid, R. (1994). Highlights of organized mental health services in 1990 and major national and state trends. In Mental Health, 1994, Manderscheid, R., and Sonnenschein, M. (eds.). Washington, DC: Superintendent of Documents, US Government Printing Office.

Russakoff, L., and Oldham, M. (1984). Group psychotherapy on a short term treatment unit: an application of object relations theory. International Journal of Group Psychotherapy, 34(3), 339-354.

Sautter, F., Heaney, C., and O'Neill, P. (1991). A problem solving approach to group psychotherapy in the inpatient milieu. Hospital and Community Psychiatry, 42(8), 814-817.

Smith, B. (1991). Managing mental health. Personnel, 68(10), 1-2.

Spitz, H. (1996). Group psychotherapy and managed mental health care: a clinical guide for providers. New York: Brunner/Mazel, Inc.

Spivack, G., Platt, J., and Shure, M. (1976). The problem solving approach to adjustment. San Francisco: Jossey-Bass.

Standish, C., and Semad, E. (1951). Group psychotherapy with psychotics. Journal of Psychiatric Social Work, 20, 143-150.

Toseland, R., and Siporin, M. (1986). When to recommend group treatment: a review of the clinical and research literature. International Journal of Group Psychotherapy, 32, 171-201.

Wender, L. (1936). The dynamics of group psychotherapy and its application. Journal of Nervous and Mental Diseases, 84, 54-60.

Winegar, N., Bistline, J., and Sheridan, S. (1992). Implementing a group therapy program in a managed care setting: combining cost effectiveness and quality care. Families in Society: The Journal of Contemporary Human Services, 73(1), 56-58.

Winer, J., and Ornstein, E. (1994). Relational themes in the inpatient community meeting. International Journal of Group Psychotherapy, 44(3), 313-332.

Witkin, M., Atay, J., Sonnenschein, M., and Manderscheid, R. (1995). Mental Health Directory, 1995. Washington, DC: Superintendent of Documents, US Government Printing Office.

Yalom, I. (1970). The theory and practice of group psychotherapy. New York: Basic Books.

Yalom, I. (1975). The theory and practice of group psychotherapy (2nd ed.). New York: Basic Books.

Yalom, I. (1983). Group inpatient psychotherapy. New York: Basic Books.

Yalom, I. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.

Zimpfer, D. (1984). Patterns and trends in group work. Journal for Specialists in Group Work, November, 1984.

Zimpfer, D. (1987). Group work with psychiatric patients. Journal for Specialists in Group Work March, 49

Appendix A

GENERAL HOSPITAL PSYCHIATRIC UNIT
SURVEY

Your title: _____

Please answer each question as indicated. If exact numbers are not known, please approximate.

I. HOSPITAL DESCRIPTION

- | | |
|---|---|
| <p>1. Licensed as what type of unit?
____ Psychiatric
____ Chemical Dependency
____ Both</p> <p>2. Number of Beds
____ Locked Unit
____ Open Unit
____ Total</p> <p>3. Average Daily Patient Occupancy
____ Locked Unit
____ Open Unit
____ Total</p> | <p>4. Of total average daily patient occupancy, number that are
____ Voluntary
____ Involuntary</p> <p>5. Average Patient Length of Stay (days)
_____</p> <p>6. Diagnostic Related Group(DRG) Exempt Unit?
____ Yes ____ No</p> <p>7. Does the unit incorporate or aspire to the principles
of the therapeutic community or milieu?
____ Yes
____ No</p> |
|---|---|

II. STAFF

8. Professional Staffing (number)

	<u>Full-time Employee</u>	<u>Part-time Employee</u>	<u>Independent Contractor</u>	<u>Total</u>
Psychiatrists	_____	_____	_____	_____
Psychologists	_____	_____	_____	_____
Counselors	_____	_____	_____	_____
Psychiatric Social Workers	_____	_____	_____	_____
RNC Psychiatric	_____	_____	_____	_____
RN	_____	_____	_____	_____
Activity Therapists	_____	_____	_____	_____
Other (CNA, Techs, etc.)	_____	_____	_____	_____

9. Who Provides Group Therapy? Please use numbers.

<u>Total</u>	<u>Bachelors</u>	<u>Masters</u>	<u>Doctoral</u>	<u>Combined Years Group Th. Experience</u>
_____ Physicians/Psychiatrists				_____
_____ Psychiatric Social Workers	_____	_____	_____	_____
_____ Counselors	_____	_____	_____	_____
_____ Psychologists	_____	_____	_____	_____
_____ Students (with co-therapist)	_____	_____	_____	_____
_____ Students (without co-therapist)	_____	_____	_____	_____
_____ Nurses 2 year degree	_____ RNC	_____ RN		_____
_____ Nurses 4 + year degree	_____ RNC	_____ RN		_____
_____ Other (combinations of degrees)	_____			
_____ Other	_____			

III. PATIENTS

10. Percent Age Ranges of Patients
_____ Under 18 _____ 65-84
_____ 18-35 _____ 85+
_____ 36-64

11. Percent Males and Females
_____ Males _____ Females

12. Are Any Patients Typically Excluded From All Groups?
_____ No
_____ Yes Please Describe _____

13. Please List the Three Most Frequent Diagnoses of Patients on the Unit.
1. _____
2. _____
3. _____

IV. GROUP THERAPY CONCEPTS

14. On what basis are patients assigned to specific groups? Check all that apply.
_____ a. All patients attend all groups
_____ b. Diagnosis determines which patients attend which groups
_____ c. Severity of dysfunction
_____ d. Patient's specific symptoms or functional impairments determine group assignment
_____ e. No criteria established
_____ f. Other _____

Comment _____

15. Who establishes goals for each patient for each group? Check all that apply.
- a. Group therapist and patient collaboratively
 - b. Group therapist
 - c. Treatment Team
 - d. Specific goals for each patient for each group are not established
 - e. Other _____

Comment _____

16. How are methods or techniques to be used in each group determined? Check all that apply.
- a. Based on specific symptoms or functional impairments
 - b. Based on therapist expertise and familiarity with those techniques
 - c. Groups and techniques scheduled greater than 24 hours in advance, i.e. weekly schedule
 - d. By therapist at beginning of each group session
 - e. Based on milieu at beginning of group
 - f. The methods used evolve as the group progresses
 - g. Other _____

Comment _____

17. Related to # 16, what is the primary process for determining which methods or techniques are used in each group?
- a. Based on specific symptoms or functional impairments
 - b. Based on therapist expertise and familiarity with those techniques
 - c. Groups and techniques scheduled greater than 24 hours in advance, i.e., weekly schedule
 - d. By therapist at beginning of each group session
 - e. Based on milieu at beginning of group
 - f. The methods used evolve as the group progresses
 - g. Other _____

Comment _____

18. How are benefits/risks/consequences of each group therapy explained to the patient? Check all that apply.

Documented? (If yes, specify how)

- | | | | |
|--|-----------------------------|------------------------------|-------|
| <input type="checkbox"/> a. Individual conference with patient | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> b. In group setting with all patients | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> c. Written explanation | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> d. Written and verbal explanation | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> e. No explanation provided | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> f. Other _____ | | | _____ |

Comment _____

19. How are behavioral changes that occur in the group assessed for each patient? Check all that apply.

Documented? (If yes, specify how)

- | | | | |
|---|-----------------------------|------------------------------|-------|
| <input type="checkbox"/> a. Oral report by patient | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> b. Observation by therapist | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> c. Collaboratively between therapist and patient | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> d. No assessment done | No <input type="checkbox"/> | Yes <input type="checkbox"/> | _____ |
| <input type="checkbox"/> e. Pre/Post Tests Describe _____ | | | _____ |

f. Other Describe _____

Comments _____

20. Who evaluates the overall group therapy program? Check all that apply.

- a. Program Director
 - b. Medical Director
 - c. Treatment Team
 - d. Combination of Above List Titles _____
 - e. Group therapists
 - f. Overall group therapy program not evaluated
 - g. Other _____
- Comment _____

Appendix B

GROUP THERAPY PRACTITIONER
INTERVIEW PROTOCOL

No. _____

I. GROUP THERAPY PRACTICE

1. Average Number of Patients per Group

2. Range of Patients per Group (i.e., 8-25)

3. Average Number of Group Therapies per
Seven Day Week

4. Is it mandatory that all patients attend groups?

_____ Yes
_____ No

9. Groups are

_____ Open-ended
_____ Time-Limited (specific number over time)
_____ Both Open-ended and Time-Limited

If time-limited groups are provided, please describe a typical group, i.e., stress management group, 1 hour, 3 x week, for 2 weeks

10. Usual Length of Group Therapy Sessions

_____ 1/2 hour _____ 1 Hour, 15 Min.
_____ 1 Hour _____ 1 Hour, 30 Min.
_____ Other (Describe) _____

5. Do Groups Generally Begin and End on Time?
 Yes
 No
6. Do Groups Have a Constant Meeting Place?
 Yes
 No
7. Average Number of Group Therapy Sessions a Patient Attends Prior to Discharge

8. Once Begun, Are Groups Generally Undisturbed?
 Yes
 No

11. What group therapy theoretical approaches are used, i.e., cognitive, affective, dynamic, systems, Gestalt, integrative, cognitive-behavioral, etc.?

12. Relating to #11, which theoretical approach, if any, is the most typical one used in the group program?

13. Who is responsible for designing the overall group therapy program in your institution?

Program Director Clinical Director
 Group Leaders No One
 Treatment Team (Describe) _____

Other _____

14. Using all necessary blanks, please check the various groups provided by your unit. Then rank order (1,2,3) the three most frequently provided.

<input type="checkbox"/> Interactional	<input type="checkbox"/> Medicine Educ.	<input type="checkbox"/> Analytical	<input type="checkbox"/> Goal Setting
<input type="checkbox"/> Movement	<input type="checkbox"/> Art Therapy	<input type="checkbox"/> Relaxation	<input type="checkbox"/> Transition
<input type="checkbox"/> Guided Fantasy	<input type="checkbox"/> Future Planning	<input type="checkbox"/> Living Skills	<input type="checkbox"/> Crafts
<input type="checkbox"/> Human Sexuality	<input type="checkbox"/> Problem Solving	<input type="checkbox"/> Rap	<input type="checkbox"/> Stress Management
<input type="checkbox"/> Assertiveness	<input type="checkbox"/> Motor Skills	<input type="checkbox"/> Focus	<input type="checkbox"/> Awareness Training
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Psychodrama	<input type="checkbox"/> Men's	<input type="checkbox"/> Women's
<input type="checkbox"/> Family	<input type="checkbox"/> Family Living	<input type="checkbox"/> Decision Making	<input type="checkbox"/> Coping Skills
<input type="checkbox"/> Task	<input type="checkbox"/> Discharge Planning	<input type="checkbox"/> Psychoeducational	<input type="checkbox"/> Symptom Mgmt.
<input type="checkbox"/> Social Skills	<input type="checkbox"/> Process	<input type="checkbox"/> Solution Focused	<input type="checkbox"/> Interpersonal Skills
<input type="checkbox"/> Eclectic	<input type="checkbox"/> Cognitive-behavioral	<input type="checkbox"/> Gestalt	<input type="checkbox"/> Rogerian
<input type="checkbox"/> Other _____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____

15. Please list and describe all group therapists by discipline (i.e., Counselor, Masters Degree, Licensed, 7 years). Use back of page for additional listing.

<u>Discipline</u>	<u>Degree</u>	<u>Licensed in Discipline (Y/N)</u>	<u>Years of Experience</u>
1.			
2.			

3.

4.

5.

6.

16. Please describe your training in group therapy, i.e., classes, conferences/workshops, inservices, or on the job training, etc.

II. GROUP THERAPY COMPONENTS

17. What is the process for assigning patients to group therapies?

18. Are specific group goals for each group developed?

- Yes
- No

19. How are goals for each group developed?

20. Are specific goals for each patient established for each group?

- Yes
- No

21. How are goals for each patient for each group developed?

22. Who determines techniques/procedures for each group?

- Group Leader
- Program Director
- Clinical Director
- Physician
- Treatment Team
- Other Describe _____

23. How are the procedures or techniques to be used in each group determined?

24. Are benefits/risks/consequences of each group therapy explained to the patient?

- Yes
- No

25. How are potential risks or consequences for each group identified and explained to the patient?

26. How is patient progress for each goal for each group assessed and evaluated?

27. Is the group process for each group evaluated?

- Yes
- No

28. Is the overall group therapy program assessed and evaluated?

Yes

No

29. How is the overall group therapy program assessed and evaluated?

III. GROUP THERAPY FACTORS

30. What are the desirable conditions for effective group therapy on a general hospital unit, i.e., administration support, positive physical environment, adequate training for staff, etc.?

31. Of those desirable conditions listed in #30, which are not available on your unit?

32. What are the obstacles blocking the provision of effective group therapy on general hospital psychiatric units?

33. To what extent, if any, is the provision of group therapy on your unit influenced by managed care, insurance companies, HMO'S, PPO'S, or other third party payers?

34. What are the principle challenges facing group therapy on general hospital psychiatric units in the future?

35. What are the factors that will ensure the continuing presence of group therapy on general hospital psychiatric units into the future?

Appendix C

GENERAL HOSPITAL PSYCHIATRIC UNIT SURVEY
INITIAL CONTACT WITH PROGRAM DIRECTOR
PROCEDURES

No. _____

Date _____

I. Telephone Call to Introduce Researcher and Study

1. Introduce self and ascertain operational status of unit.
2. Obtain name and title of Director of unit.
3. Confirm address and telephone number of unit.
4. Correlate name of unit with number for confidentiality purposes.

II. Nature of the Study

1. Description of study including current state of the art and methods to be used.
2. Describe and assure confidentiality.
3. Indicate time involvement.

III. Advantages of Participation

1. Update of current state of the art.
2. Ability to compare operational aspects of unit, such as staffing patterns, length of stay, and occupancy with all other programs in Virginia.
3. Assessment of clinical components of current group therapy practices of each unit, thereby also providing method of comparison to other general hospital group therapy practices in Virginia.
4. Provision of information to develop more effective group therapy practices.
5. Summarized group therapy practitioner descriptions of desirable factors for effective group therapy provision on general hospital psychiatric units, thereby providing information toward potential obstacles for the provision of effective group therapy on each unit.

IV. Closure of Telephone Contact

1. Appreciation of time and effort.
2. Questions and comments.

V. Follow-up

1. Follow-up thank you letter (after return of survey) Date: _____
2. Results Requested ___ Yes ___ No If yes, date sent: _____

May 28, 1997

Program Director
Address
City, State, Zip

Dear Program Director:

As a follow-up to our telephone conversation on May 23, 1997, I am sending the materials I reviewed with you. As you now know, I am very interested in studying the current status of group therapy in general hospital psychiatric units. As a Program Director, you are very knowledgeable of the current practices of group therapy on these psychiatric units. Thank you for taking about 15 minutes with this research.

Enclosed is a General Hospital Psychiatric Unit Survey relating to practices and procedures on your psychiatric unit. The information you provide will be considered confidential for you and your institution at all times. The questionnaires are numbered only to assist with follow-up and tracking. I alone will have access to a master file linking numbers to hospitals and this will be destroyed once data collection has been completed.

Also enclosed please find two copies of an Informed Consent for Participation in this study. Please read and keep one copy while signing and returning the other copy with the survey. I appreciate your completion and return of the survey by June 18, 1997.

As we discussed on the telephone, very valuable information about inpatient units and inpatient group therapy will be obtained and I will be happy to share this with you.

Thanks for your help. Your assistance will contribute to the success of this study and the continued development of inpatient group therapy.

Sincerely,

Patrick N. Farley
Director of Behavioral Health Services

cc: David Hutchins, Ph.D., Program Area Leader
Counselor Education, Virginia Tech

Appendix E

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

**Informed Consent for Participants
of Investigative Projects**

Title of Project: Current Trends in General Hospital Group Psychotherapy

Investigator: Patrick N. Farley David E. Hutchins, Ph.D.-- Faculty Advisor

I. The Purpose of this Research Project

The purpose of this survey study is to assess the current practice of group therapy in general hospital psychiatric units in _____ and to determine whether there is a need for a more systematic method of designing, implementing, and evaluating general hospital group therapy. Two procedures will be utilized: 1) The General Hospital Psychiatric Unit Survey (GHPUS); and 2) The Group Therapy Practitioner Interviews (GTPI).

The GHPUS will be administered to the Directors of Psychiatric Units in general hospitals in _____. The GTPI will be conducted on-site with six group therapy practitioners providing group therapy services on a general hospital psychiatric unit in _____. The six will be chosen from the pool of responding units given the GHPUS.

II. Procedures

All Directors of Psychiatric Units in General Hospitals in _____ will receive the General Hospital Psychiatric Unit Survey and this Informed Consent form. The Directors' responsibility are to read and sign the Informed Consent form, complete the GHPUS, and return both in the postage paid envelope provided. Completion of the Informed Consent and the survey will take approximately 15 minutes. This is a one time survey administration and can be completed at the Directors' offices.

Six psychiatric units from the pool of responders to the GHPUS will be chosen. The three largest and three smallest units will be chosen based on number of available beds. The Directors of each unit will be contacted by telephone and an appointment will be requested with a group therapy practitioner on that unit.

The investigator will meet with the group therapy practitioner to discuss this Informed Consent form and administer the GTPI. The interview will last approximately 45 minutes. The

practitioners' responsibility is to read and sign the Informed Consent form and to answer the questions on the GTPI protocol as asked by the interviewer.

III. Risks

There are no risks or discomforts to any research subjects.

IV. Benefits of this Project

This study will summarize current practices of group therapy on general hospital psychiatric units in _____, thereby clarifying a vague picture of the current state of the art. Additionally, this study will assess the current use of the components of a model for the development, implementation, and evaluation of group therapy. This information could be beneficial in developing more effective group therapy programs in general hospitals. Finally, this study will summarize desirable factors of effective psychiatric unit group therapy as reported by practitioners of the service, thereby providing information toward the development of a systematic approach to general hospital psychiatric unit group therapy.

No promise or guarantee of benefits has been made to encourage me to participate.

I am aware I may receive a copy of the results of this research.

V. Extent of Anonymity and Confidentiality

The identity of general hospital psychiatric units will be known only to the investigator. Each GHPUS will be identified with a number which will correspond with the name of the unit. Only the investigator will have access to the numbers and corresponding unit names. This information as well as all data will be held under lock and key unless in the investigator's possession.

Confidentiality will be ensured in that at no time will the investigator release any data about any participant or specific institution without the written consent of participants.

All data and identifying information will be destroyed at the end of the study.

VI. Compensation

There is no compensation to be earned for participation in this study.

VII. Freedom to Withdraw

I understand I am free to withdraw from the study at any time and, if I so choose, to not answer any questions on the survey.

VIII. Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, and by the Department of Educational Leadership and Policy Studies.

IX. Subject's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

1. If a Unit Director or Administrator, to complete the General Hospital Psychiatric Unit Survey and return it in the postage paid envelope to the investigator.
2. If a group therapy practitioner, to participate in the Group Therapy Practitioner Interview conducted by the investigator.

X. Subject's Permission

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project. I have received a copy of this Consent.

If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

Signature	Date
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Should I have any questions about this research or its conduct, I may contact:

Patrick N. Farley	(304) 425-3970
Investigator	Telephone

David E. Hutchins, Ph.D.	(540) 231-9703
Faculty Advisor	Telephone

H. T. Hurd	(540) 231-5281
Chair, IRB Research Division	Telephone

June 26, 1997

Program Director
Address
City, State, Zip

Dear Program Director:

I am writing you to follow-up on a survey I had recently sent to you regarding group therapy and general hospital psychiatric units in Virginia. To date, more than 50 % of your fellow Program Directors have returned their completed materials but I have not yet received your completed survey.

As you know, group therapy has become an extremely important treatment modality in the treatment of patients on your unit. As a result, third party payers, patients, hospital administrations, and therapists are enacting and experiencing significant changes in how group therapy is provided. This study will assist in understanding the current practice and direction of general hospital group therapy.

With this letter you will find enclosed a General Hospital Psychiatric Unit Survey relating to practices and procedures on your psychiatric unit. The survey should require a total of 15 minutes of your time. The information you provide will be considered confidential for you and your institution at all times. The questionnaires are numbered to assist with follow-up and tracking. I alone will have access to a master file linking numbers to hospitals

Will you please complete and return the survey to me in the enclosed postage paid envelope? Also, enclosed please find two copies of an Informed Consent for Participation in this study. Please read and keep one copy while signing and returning the other copy with the survey.

Information from this study will be available to you upon request. You may contact me at the above address for a copy of the results. Your individual response is essential for the success of this study.

Thanks for your help.

Sincerely,

Patrick N. Farley
Director of Behavioral Health Services

cc: David Hutchins, Ph.D., Program Area Leader
Counselor Education, Virginia Tech

Appendix G

GROUP THERAPY PRACTITIONER
ONSITE INTERVIEW PROCEDURES

No. _____

I. Interview Set-Up

- A). Telephone call to introduce interview and set up appointment. Date: _____
1. Description of Study
 2. Describe Confidentiality
 3. Indicate Time Involvement
- B). Appointment Confirmation Letter
1. Summarize I.A).
 2. Confirm appointment date, time, and place Date: _____
 3. Answer questions as indicated Time: _____

II. Conducting the Interview

- A). Brief Introduction as Above
- B). Review Informed Consent for Participants
- C). Recording of Responses

III. Closure of Interview

- A). Appreciation of Time and Effort
- B). Questions and Comments

IV. Follow-up

- A). Follow-up Thank You Letter Date: _____
- B). Results Requested ____ Yes ____ No If Yes, Date Sent: _____

August 20, 1997

Program Director or Group Therapy Practitioner
Address
City, State, Zip

Dear Program Director:

As a follow-up to our telephone conversation on August 18, 1997, this letter confirms that I will interview _____ (Group Therapy Practitioner) on _____ (date) at _____ (time). This interview, which should last approximately one hour, will take place at _____ (Name of Hospital and location within hospital).

I appreciate the time and effort from you and your staff for this research. As I discussed with you, I will be happy to respond to any questions and will provide a copy of the results to you.

Again, thank you for helping to increase our knowledge about inpatient group therapy. I look forward to seeing you soon.

Sincerely,

Patrick N. Farley
Director of Behavioral Health Services
Russell County Medical Center

cc: David Hutchins, Ph.D.
Program Area Leader
Counselor Education
Virginia Tech

Date

Program Director or Group Therapy Practitioner
Address
City, State, Zip

Dear Program Director or Group Therapy Practitioner:

Earlier this year you participated in research related to the current status of group therapy in general hospital psychiatric units across Virginia. Enclosed you will find, as requested, a copy of the results of that research which has provided a very valuable update of practices and trends on these units.

This information could not have been compiled had it not been for your cooperation and participation. Thank you for your involvement.

If you have any questions or comments, please do not hesitate to contact me.

Best Wishes,

Patrick N. Farley
Director of Behavioral Health Services
Russell County Medical Center

VITAE

PATRICK N. FARLEY
143 MOUNTAIN VIEW DRIVE
ABINGDON, VIRGINIA 24211

(540) 676-0585 (H)
(540) 889-0514 (O)

License #2158, Professional Counselor
State of North Carolina
License #34, Professional Counselor
State of West Virginia
National Certified Counselor, #22333
National Board of Certified Counselors

EDUCATION

Virginia Polytechnic Institute and State University: Doctor of Education (Ed.D.) in Counselor Education. Cognate in Management and Administration. February, 1998.

Marshall University: Master of Arts in Counseling. Minor in Psychology. August, 1975.

Marshall University: Bachelor of Arts in Psychology. December 1973.

Grantsmanship Center, Washington, D.C., "Business Ventures for Non-Profits: Development and Initiation of Small Business," June, 1984.

Associate Trainers in Clinical Hypnosis, Tampa, Florida. Basic and Advanced Training in Clinical Hypnosis, November, 1982.

University of Alabama in Birmingham: Management Training in Administration and Management Skills. May-June, 1981.

Personal Dynamics Institute, Minneapolis, Minnesota: Certified Coordinator in Attitude Assessment and Training. June, 1979.

University of Kentucky College of Medicine: Certification in Rational Emotive Therapy. May-June, 1978.

Huntington Institute for Rational Living, Huntington, West Virginia: Associate Fellowship Training for Rational Emotive Therapy. June-December, 1975.

EMPLOYMENT

DIRECTOR OF BEHAVIORAL HEALTH SERVICES, Russell County Medical Center, Lebanon, Virginia. May, 1997-Present. The Director is responsible for the clinical and fiscal development and maintenance of a 20 bed, adult psychiatric unit, a Partial Hospitalization Program, Outpatient Services, and Psychiatric Home Health Services. All duties and responsibilities concerning the operation of these four psychiatric settings are under his supervision.

PROGRAM DIRECTOR, Psychiatric Services, Twin County Regional Hospital, Galax, Virginia. December, 1994 - August, 1996. The Program Director is actually employed by Diamond Healthcare Corporation, Richmond, Virginia, as a consultant and member of the staff at Twin County Regional Hospital.

The Program Director has the control of and responsibility for the 14 bed inpatient general psychiatric unit, a 15 bed partial Hospitalization Program, and an Outpatient Psychiatric Clinic. All financial and programmatic aspects are under his supervision. Recruitment of non nursing personnel, psychiatrists, psychologists, social workers, recreational therapist, occupational therapist, as well as all aspects of supervision are also his responsibility.

The educational development of all staff and liaison with community resources and referral sources are part of his duties. The Program Director is additionally charged with preparing the integrated services for JCAHO, Medicare, and Department of Health Reviews.

PRIVATE PRACTICE, Princeton, West Virginia, January, 1989 - November, 1994. Private Practice Counseling in Princeton, West Virginia. Individual, family, marital, substance abuse, and adolescent counseling for a wide range of psychological disorders. I also set up Employee Assistance Programs and provided seminars to the public as well as other health care providers. Stress management evaluation and treatment was provided to HEARTCARE, a cardiac rehabilitation unit.

CLINICAL COORDINATOR, Behavioral Medicine Center, Princeton Community Hospital, Princeton, West Virginia. August, 1987 to June, 1992. The Clinical Coordinator assesses the overall clinical operation of the 26 bed inpatient psychiatric unit at Princeton Community Hospital. This includes the determination of the type, frequency and quality of all treatment modalities for all psychiatric patients. The Clinical Coordinator supervises all psychologists, social workers, counselors, or activities therapists working on the unit. Therapy including individual, group, family, marriage, and adolescence is provided. This position is also responsible for mental health training and education for nursing and other hospital personnel.

PRIVATE PRACTICE, Human Development and Counseling Center, Princeton, West Virginia, March, 1982 to December, 1988. This private practice offered all therapy modalities for a broad range of diagnostic categories and ages. Workshops and seminars were provided to the public.

DIRECTOR OF MENTAL HEALTH SERVICES, Southern Highlands Community Mental Health Center, Princeton, West Virginia. July, 1985, to August, 1987. The director assesses the operation of mental health programs and develops methods and techniques to assure appropriate delivery of mental health services in compliance with directives from funding sources. This position makes decisions that affect centerwide policies and procedures and is involved in planning and implementing staff development, management, and employment. Additionally, the director provides therapy services including initial evaluation and crisis counseling. Grant writing, staff performance evaluation and quality assurance were responsibilities.

DIRECTOR OF PSYCHOLOGICAL SERVICES, Southern Highlands Community Mental Health Center, Princeton, West Virginia. July, 1982 to July, 1985.

DIRECTOR OF CRISIS STABILIZATION SERVICES, Southern Highlands Community Mental Health Center, Princeton, West Virginia. June, 1980 to July, 1982.

PSYCHOTHERAPIST, Southern Highlands Community Mental Health Center, Princeton, West Virginia. August, 1976, to August, 1987.

DIRECTOR AND THERAPIST IN CHIEF, Shawnee Hills Community Mental Health Center, Clay, West Virginia. January, 1976, to August, 1976. The director supervised all administrative and clinical aspects of the clinic, hired and supervised all staff, and maintained an individual and group therapy caseload that was provided on a daily basis.

THERAPIST, Hibbard Psychiatric Clinic, Huntington, West Virginia. June, 1975 to January, 1976.

PROFESSIONAL AFFILIATIONS and POSITIONS

- American Counseling Association
- American Mental Health Counselor Association, Charter Member
- Past State Coordinator, West Virginia Mental Health Counselors Association, 1977 - 1979.
- Past Vice Chairperson, Behavioral Health Advisory Council, Department of Health, State of West Virginia, providing input directly to the Commissioner of the State Department of Health on Mental Health and Substance Abuse issues.
- West Virginia Mental Health Advisory Council, appointed by Governor Gaston Caperton, August, 1989, to June, 1991.
- Chairperson, Advisory Council, Southern Regional Juvenile Detention Center.
- Deacon, Presbyterian Church, Princeton, West Virginia, 1990-1995.
- President, Parent-Teacher Organization (PTO), Mercer Elementary School, Princeton, Virginia, 1991-1994.