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Therapeutic Factors Within In-patient and Out-patient Psychotherapy Groups

Implications for Therapeutic Techniques

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Therapeutic factors operative in in-patient and out-patient therapy groups were compared. These settings differ greatly, both in terms of the patient population they serve and the overall systems within which they operate. The study revealed significant differences between the therapeutic factors operative in these two settings, and suggested that clinicians should modify their techniques for running psychotherapy groups across settings, to take account of these findings.

In the past decade there has been an upsurge of research into therapeutic factors in group psychotherapy. This is primarily related to Yalom's (1975) conceptualisation of group processes into 12 therapeutic factors (Table I). This conceptualisation has subsequently been adopted by researchers working with out-patient groups where they have examined those factors perceived most helpful by group members (e.g. Butler & Fuhriman, 1980, 1983). However, research into in-patient group treatments is in its infancy: both clinicians and researchers have only recently ventured into this difficult area of clinical practice (Klein, 1977). This paper aims to explore the therapeutic factors operating in both in-patient and out-patient psychotherapy groups, so as to provide guidelines for clinicians running groups in these contrasting areas of psychiatric practice.

Method

Subjects

In-patient subjects consisted of 42 patients who had an in-patient group experience. In adopting the criterion of a patient's attendance at three or more group sessions for inclusion in the study, we found that our sample size dropped to under half ($n = 22$). This feature is common to in-patient investigations, although our sample compares favourably with other studies (Marcovitz & Smith, 1983; Leszcz *et al*, 1985). Most of the in-patients suffered from an affective disorder (64%), with a small percentage exhibiting a psychotic state (13.5%); other diagnostic categories were anorexia (4.5%), personality disorder (9%), and alcohol dependence (9%). Of the final in-patient sample, 64% were female and 36% were male.

The out-patient sample consisted of 25 patients who had been primarily referred for long-term group psychotherapy. Most of them suffered from either an anxiety state (20%) or an affective condition (56%). The male/female ratio was similar to that of the in-patient sample. Most of the out-patient referrals originated from general practitioners, although some were made by psychiatrists or mental health professionals.

Description of the groups

(i) In-patient groups

Data were collected from three in-patient groups operating in three different acute admission units. All groups followed closely the format of the higher-level in-patient group devised by Yalom (1983). This involved focusing on interpersonal feedback concerning here-and-now behaviour. A clinical description of this type of group was outlined by Kapur *et al* (1986). The groups met for one and a quarter hours, twice weekly. The nature of the in-patient setting meant that therapeutic work was discontinuous between sessions, the focus of activity being very much within the time frame of the group session. All three therapists had previous experience of group psychotherapy.

(ii) Out-patient groups

RK was responsible for the running of the out-patient groups. A clinical description of this type of group is outlined elsewhere (Kapur, 1986*a*,*b*). The model of psychotherapy followed that described by Yalom (1975), which highlights interpersonal processes and psychogenetic insight. Data were collected from three long-term psychotherapy groups. These groups met weekly during, on average, 2 years. Using the core-group psychotherapy self-assessment kit (McKenzie & Dies, 1982), an outcome evaluation, in preparation, indicates that these groups were effective.

Procedure

The instrument used to measure therapeutic factors was adapted from Yalom's therapeutic factor questionnaire

TABLE I
Definitions of Yalom's 12 therapeutic factors (taken from Bloch & Crouch, 1985 and Yalom, 1975)

Factor	*Definition*
Altruism	The patient feeling better about himself or herself, or learning something positive about himself, through the help he extends to his fellow members.
Cohesiveness	A feeling of togetherness, *esprit de corps*, experienced by group members. The patient feels accepted and no longer isolated from others.
Universality	The patient perceives that other group members have similar problems and feelings, this perception reducing his sense of uniqueness.
Interpersonal learning (input)	The patient learns more clearly about the nature of his problems through other group members sharing their perception of him.
Interpersonal learning (output)	The group provides an opportunity for the patient to relate to others in a more adaptive way. It is a form of 'interpersonal experimentation'.
Guidance	This relates to the imparting of information and giving of advice either by the therapist or other group members.
Catharsis	This occurs when a patient releases feelings, leading to relief, of past or here-and-now material. These feelings include anger, affection, sorrow, and grief which have previously been difficult or impossible to discharge.
Identification	This occurs when the patient considers himself to be like another group member or therapist and models his own behaviour after him.
Family re-enactment	This refers to the opportunity for the corrective recapitulation of the primary family experience within the group.
Self-understanding	This factor could be called psychogenetic insight in as much as the patient learns about the mechanisms underlying his behaviour and about its origin.
Instillation of hope	The patient sees that other members have improved or are improving and that the group can be helpful; he is thus optimistic about the group's potential to help him too.
Existential	This refers to the theme of the patient ultimately accepting that he has to take responsibility for his own life.

(Yalom, 1975). The questionnaire* contains 60 items, 5 describing each of 12 factors. Demographic information and details of previous individual and/or group therapy were collected at the same time.

Patients were asked to consider each of the 12 items (presented on five separate pages) and rank each item from the most helpful (1) to the least helpful (12). The data thus comprised five rankings per therapeutic factor.

Dies (1985) has pointed to the importance of considering *when* to administer measures of group process. In the present study, we were faced with the issue of comparing a short-term, time-limited group (in-patients) with an open-ended longer-term psychotherapy group (out-patients). In an attempt to resolve this difficulty, we chose the most representative point at which to measure therapeutic factors.

For in-patients, questionnaires were administered either after the third session (if discharge was imminent) or, if the patient remained in the group, after the final session.

The average number of sessions was 5.8. The unpredictable turnover rate within the acute units meant that attendance at sessions ranged from 3 (minimum)–14. As the model of group therapy adopted was specifically of a 'one session' kind (Yalom, 1983), we would not expect any significant developmental changes after the subject had become acquainted with the group.

*Copies of the questionnaire are available on request.

With the out-patient group, we decided to measure therapeutic factors at the mid-point of the group's development. Accordingly, data were collected at or near the fiftieth session. Within the out-patient groups, the drop-out rate stabilised after the first 6 months (the rate was 31%). This figure is consistent with previous research findings in out-patient groups which point to a range of 20–50% in the first 6 months (Rutan & Stone, 1984). The drop-outs were replaced, and the subsequent drop-out rate from 6 months to the end of the group was 9%. Thus, at the point of administering the questionnaire, most group members had become acquainted with the group, and the percentage who completed the questionnaire and then dropped out was small. We therefore concluded that the final out-patient sample was representative of out-patients actively participating in group psychotherapy.

The procedural restrictions in comparing groups with a different time span could be seen to invalidate the findings. Clearly, the time variable could influence our results, but our experience, coupled with that of previous researchers (Leszcz *et al*, 1985), suggests that the specifically one-session design of the in-patient groups allows for comparison with longer out-patient groups. However, it must be remembered that the out-patient data presented in this study relate to the middle and more advanced stage of a psychotherapy group, where leader skills are different from those necessary for beginning a group. Consequently, the out-patient findings and subsequent recommendations contained within

our study relate primarily to those groups which have been well established. The aim of the present study was to locate the most representative point and then to perform a comparison. Future research would seek to standardise this important variable, and so clarify its influence on the dependent variable.

Results

Table II presents the mean rank scores for the 12 therapeutic factors. A Mann–Whitney U test was employed to examine the differences in the rankings between the two samples. The differences in mean rankings made by the two groups were statistically significant for seven of the twelve therapeutic factors.

These results show that in-patients and out-patients differ considerably in terms of therapeutic factors perceived to be helpful. In particular, in-patients valued altruism and a consideration of existential issues surrounding their admission to hospital. The out-patients especially valued self-understanding. Both patient groups placed a high value on cohesiveness and universality.

Discussion

The major methodological difficulties in this study were lack of control over therapist variables, the relatively high drop-out rate in the in-patient sample, and the difference in timing of the questionnaire's administration between these two groups. While these factors may have affected the results, we agree with Dies's (1985) conclusion that: "It is impossible to investigate group process without significant compromises in experimental vigour. To do otherwise would often raise serious questions that what we are investigating is not treatment as a natural occurrence but an artificial system contrived by the experimenter".

In-patients ranked altruism as the second most helpful factor, whereas out-patients ranked it very low. This finding replicates those of previous research (Maxmen & Hanover, 1973; Yalom 1975; Butler & Fuhriman, 1980; Marcovitz & Smith, 1983; Kahn *et al*, 1986; Whalan & Mushat 1986). It seems that in-patients receive tremendous positive feedback and feel increased self-esteem through being able to help others. Thus, clinicians operating in-patient groups should encourage this type of 'peer-group therapy'. In contrast, out-patients place less value on this factor, perhaps realising that longer-term altruistic behaviour may occur at the cost of neglecting their own needs (Arieti & Bemporad, 1978). However, it is difficult to interpret the exact meaning of this behaviour, as altruistic behaviour can also be seen as a defence against self-disclosure or a step forward in psychological maturation (Erikson, 1982).

Self-understanding was ranked first by out-patients, which is consistent with previous research (Yalom, 1975; Butler & Fuhriman, 1980, 1983; Leszcz *et al*, 1985). In contrast, in-patients ranked this as eighth most helpful. For out-patients, self-understanding remains the cornerstone of their therapeutic experience which facilitates personal change (Bloch & Crouch, 1985). For in-patients, exploration into reasons behind their distress may be contra-indicated within such a short-term setting. Futhermore, the anxiety-provoking nature of self-understanding (Butler & Fuhriman, 1983) renders this technique inappropriate for disturbed and fragile patients. Rather, some degree of interpersonal learning is probably easier to assimilate and less anxiety-provoking for in-patients.

Family re-enactment was ranked as the ninth most helpful by out-patients, while the in-patients ranked this eleventh. These rankings are consistent with previous research, which has shown low rankings for both in-patient and out-patient samples (Maxmen & Hanover, 1973; Yalom, 1975; Butler & Fuhriman, 1983; Marcovitz & Smith, 1983; Kahn *et al*, 1986). The higher ranking by the out-patients possibly reflects the longer duration of their group therapy whereby multiple transferences (Slavson, 1964; Yalom, 1975; Grotjahn, 1977) can develop. These transferences act as 'grist for the therapeutic mill' and provide material for interpretation by the therapist. The rapid turnover of patients in the in-patient groups prevents such transference development.

The in-patients ranked the existential factor as more helpful than did the out-patients. Previous research has produced inconsistent findings in both in-patient and out-patient groups (Maxmen & Hanover, 1973; Yalom, 1975; Butler & Fuhriman, 1980; Schaffer & Dreyer, 1982; Marcovitz & Smith, 1983; Leszcz *et al*, 1985; Kahn *et al*, 1986). The higher ranking achieved by in-patients may reflect the existential crisis that often faces a patient on an acute psychiatric ward. Issues of personal responsibility and solitude predominate at this time, and results indicate that patients find it helpful to discuss these issues.

In-patients and out-patients both ranked cohesiveness highly – a finding consistent with other research (Maxmen & Hanover, 1973; Yalom, 1975; Butler & Fuhriman, 1980, 1983; Marcovitz & Smith, 1983; Whalan & Mushet, 1986). Cohesiveness has long been acknowledged as having potent therapeutic benefit in psychotherapy groups (Bloch & Crouch, 1985); group therapists have pointed to its positive correlation with successful outcome (Yalom, 1975). It is clear from our findings that this is a highly valued factor which requires promotion across both types of groups.

TABLE II
Mean rank scores for the 12 therapeutic factors: out-patient and in-patient samples

Factor	Mean rank score*		P
	Out-patient	In-patient	
Altruism	7.23	4.90	0.001
Cohesiveness	5.85	4.89	0.05
Universality	5.60	5.44	NS
Interpersonal learning–input	6.53	5.90	NS
Interpersonal learning–output	6.49	5.52	0.05
Guidance	7.14	8.13	0.05
Catharsis	6.50	5.83	NS
Identification	9.49	9.77	NS
Family re-enactment	6.54	8.94	0.001
Self-understanding	4.22	6.23	0.001
Instillation of hope	6.53	6.65	NS
Existential factor	6.39	5.18	0.01

*Factors are ranked from 1–12, with 1 representing the most helpful rank and 12 the least helpful.

The above in-patient finding may be confusing when examined within the context of a setting that has practical barriers to the formation of cohesion: the high turnover of members and the discontinuity between group sessions. However, the other group contacts made available by patients who live together for 24 hours a day ensures that cohesion can develop. The feeling of being accepted and supported by others is critical for in-patients who suffer from a sense of worthlessness and despair.

Both kinds of group ranked guidance very low. This finding is consistent with previous research (Maxmen & Hanover, 1973; Yalom, 1975; Butler & Fuhriman, 1980, 1983; Marcovitz & Smith, 1983; Leszcz *et al*, 1985). Out-patients perceived guidance to be slightly more helpful than did in-patients. The greater continuity evident within out-patient groups possibly explains this result. Advice given by other group members can be reviewed and reported back to the group in subsequent sessions. The in-patients do not have this opportunity due to rapid turnover of membership.

Finally, in-patients valued interpersonal learning (output) slightly more highly than out-patients, which may reflect the here-and-now interpersonal focus of Yalom's (1983) model of in-patient psychotherapy. This suggests that group members are tentatively beginning to relate to others, and to try out new ways of doing so.

Conclusion

Clear differences emerge between the therapeutic factors perceived to be helpful by members of short-term in-patient and long-term out-patient psychotherapy groups. The former value altruism, cohesiveness and existential factors, whereas the latter perceive self-understanding, universality, and cohesiveness as particularly helpful. These differences have implications for the optimal therapeutic approach in these two settings. In-patient group therapists should encourage factors related to here-and-now interpersonal behaviour, cohesiveness and altruism. By contrast, it is more appropriate for out-patient group psychotherapists to focus on the 'deeper' cognitive factors. Further research concerning these factors can lead to their more appropriate application in the two clinical settings.

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