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Interpersonal group therapy on acute inpatient wards

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Abstract: *The present paper describes the therapeutic application of Yalom's interpersonal model to inpatient groups. The basic characteristics of the model are outlined, followed by goal formulation. A good ward group engages patients, reduces their sense of isolation, helps deal with anxiety caused by hospitalisation and provides the experience of 'universality' and of being helpful to others. Structured group tasks are utilised to facilitate disclosure, acceptance, feedback and personal change. Finally, a case study is described on the use of the Yalom groupwork method on an acute inpatient ward. While these groups have been found to be very helpful by patients, further work is needed on their evaluation.*

Keywords: *Yalom's interpersonal model; working with tasks; acute inpatients; group therapy*

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Introduction

Groups on acute inpatient wards are notoriously difficult to run and the topic only receives scant attention in writings on group therapy (Aveline and Dryden, 1988; Burlingame, MacKenzie and Strauss, 2004). There are several reasons for this. Patients stay for only relatively short periods of time and the patient turnover is high; patients are acutely ill and sometimes heavily medicated which makes therapeutic engagement a challenge; and it is usually difficult to motivate patients to attend a group. At the same time groups can provide an important socialising influence, make a substantial contribution to the therapeutic environment of the ward, and can be used to add structure, purpose, and therapeutic elements to the hospital stay which can sometimes be empty and unproductive.

One model of group treatment designed to be practicable and useful in the inpatient environment has been proposed by Irving Yalom (Yalom, 1983). In this presentation I will first briefly describe this approach which its author calls the 'interpersonal model', and elaborate on the differences between out-patients and inpatient groups. I will then present our experience with running such groups on an all male acute inpatient ward in Lambeth, South London.

Yalom's interpersonal model

Our behaviour, adaptive and maladaptive, is formed in a social context and is influenced by interpersonal relationships with parents, friends, peers, teachers, partners, etc. Our mental health is also influenced by, and dependent on interpersonal relationships. It is often the case that people with mental health problems have had difficult relationships with other people in the past and that they keep having problems with creating and maintaining satisfying relationships in their adult life. This can of course be the cause or the result of their mental health problems. Yalom posits that whichever way the causality goes, adjustments in this all-important area are essential for mental health and they can only be achieved through interactions with other people. Interpersonal interactions can facilitate changes in behaviour, and a group setting provides a unique opportunity for developing interpersonal skills,

and for giving and receiving mutual support and social validation and feedback.

In a group setting people not only talk about their problems or difficulties, they also demonstrate them. A person who has difficulty with controlling their anger is very likely to become angry in the group and thus demonstrate the problem there and then. Someone who is normally isolated and does not engage in social intercourse will behave in the same way in the group. Groups can help a person to become aware of such patterns, and provide learning opportunities for trying to control or modify maladaptive routines.

The group as a social microcosm

The group is a 'microcosm' of society. It is very likely that people in the therapy group will be from different ethnic and cultural backgrounds, from different professions and social classes, and they will have different attitudes and belief systems. The group will mimic the society. This provides an opportunity to be confronted with views, ideas and behaviour patterns which may be different from one's own, and helps a person to consider their own behaviour and relationships.

Focus on 'here and now'

One of the key elements of the interpersonal model is the focus on the 'here and now.' The group deals with what is present and the facilitator tries to bring the material into the 'here and now.' Talking about the past or about outside and impersonal issues (such as the political situation) is discouraged. It is explained that the group is about them and about what happens between them and the other group members in the room.

The differences between the outpatient and inpatient groups

Outpatient groups usually have between six and 10 members who meet regularly over a period of weeks or months. There is a stable membership

and sufficient time to get to know each other well. Members of the outpatient group are not acutely ill, and they are usually functioning quite well in the outside world.

Inpatient groups, on the other hand have a very high turnover of patients (some patients may only stay on the ward for a few days, others may stay for several months). Some patients may attend only one or two group sessions, others might attend six or seven. Patients are acutely mentally ill and have a wide variety of symptoms. Some people may be uncomfortable or suspicious about attending the group. The acute psychiatric ward is a radically different clinical setting and demands a radical modification of therapeutic goals and techniques,(Yalom, 1983; 1985).

Formulation of goals

A clear set of goals need to be established which are clear to the therapist and to the patients. It is often the case that inexperienced therapists start running a group without thinking through the model, the format, and what the group is trying to achieve. They are hoping that when patients come together, they will be able to talk about their feelings or find themes to discuss. Such a group can disintegrate quickly and generate feelings of failure.

The goals of the group should be limited, achievable and tailored to the capacity and potential of group members. A group needs to provide a positive experience for the patients to want to attend again. For some, it may be an achievement just to attend a group and listen to others for 45 minutes. It is up to the facilitator to make sure that every involvement, no matter how small, is appreciated and patients associate the completion of each group session with feelings of achievement and success.

Goals of inpatient group therapy

Groups on an inpatient ward can help to engage the patient in a therapeutic process and become the main vehicle of improving the therapeutic environment on the ward. On many acute inpatient wards the therapeutic environment suffers as other priorities (dealing with

crises, close observations, carrying out risk and other assessments, recording activities, administrative tasks, etc) take over. Some wards may appear rather chaotic. Patients may feel they are not listened to or understood. They may feel staff have other much more important things to do than talking to them. There may be no structure to the day and patients spend most of the time sitting about and waiting for the few structured events such as clinical rounds, meeting with their doctor, leave from the ward etc. The main principles of the therapeutic environment are Structure, Involvement, Containment and Support, (Lecuyer, 1992; Walker, 1994; Thomas, Shattel and Martin, 2002; Emer, 2004). All of these can be promoted by running a well structured and well functioning group.

Engaging the patient in the therapeutic process

In the group the patient will have an opportunity to talk about their personal issues, their treatment and any difficulties, to obtain feedback from other group members and from the group facilitator. This allows patients to become more active participants in their treatment.

Reducing isolation

Patients who are normally quite isolated will get involved in the discussion and will be rewarded for sharing their ideas. Attending the group helps patients to form relationships and social networks in an environment which can otherwise be impersonal and alienating.

Reducing anxiety connected with hospitalisation

Many patients will feel anxious about being in the hospital. For some it may be their first admission and they are frightened by the new environment and by being among mentally ill people. Many patients will be in hospital on an involuntary basis (under the Mental Health Act) and perceive their stay as coerced punishment. The group can provide an outlet for discussing such feelings and it can substantially ameliorate such anxieties and fears.

Providing experience of universality and of being helpful to others

Among the number of different therapeutic factors present in groups, realising that other people have similar experiences and being helpful to others can play a special role in this particular setting. Being able to offer help to another is normally highly rewarding and group sessions can be geared specifically to providing such experience.

Working style

Groups are structured and the facilitators are active and directive. They bring in a clear agenda. Once the group gets started, the proceedings would follow members' leads, but the clinician is always ready to offer guidance and structure if needed.

A group session normally starts with an introduction and explanation of rules and aims in terms that patients would find easy to understand. Then a task is set and members work either individually or in pairs. After the task is completed, there is a group discussion which comprises the main part of the session. Each member presents their contribution in turn. If somebody refuses to join in, this is accepted and such members are simply encouraged to listen to others and to join in when they want to do so. Following the round of presentations responding to the group task, members are asked to comment and share with the group their reactions to what was presented, to give feedback to one another, compare notes, etc. The therapist is transparent and personal. Unlike in the psychodynamic group, where it would be thought inappropriate to reveal any personal information or answer personal questions, in the interpersonal group the therapist will be ready to discuss personal information where appropriate, or answer questions about his/her feelings and reactions. The focus is on here and now. This is a focus on what is happening in the immediate session at the present time. Group members are discouraged from dwelling on events from the distant past, (although they may talk about what happened to them in the past if this is relevant to the present topic). They are encouraged to concentrate on current experiences with the aid of tasks. The facilitator helps members to be personal to one another, look at one another, direct comments to one another and address each other by their name. The task of the

therapist is to guide from abstract statements to concrete statements and guide from impersonal to personal.

Example : When a patient says : people make me angry. The facilitator may say : look around the room and say who makes you angry here. This can then be used for giving and receiving feedback. Feedback is the core element of the interpersonal/interactional approach. As feedback does not happen automatically, it is the facilitator's task to initiate feedback and to teach members of the group to give constructive feedback, and to establish group norms which will allow people to give and receive feedback in a supportive atmosphere.

Working with tasks

The clinician's task is to help the group to stay focused and to avoid raising anxiety levels by ambiguity or by allowing silences to develop. This is different from outpatient group work where lack of structure and occasional silence and tension are among the usual therapeutic tools. In the inpatient group setting an important priority is for patients to feel safe, to know what is expected and to feel that they can master the task.

The group tasks are designed to facilitate disclosure, acceptance, feedback and personal change.

Disclosure

For the inpatient group to work, members need to feel that something relevant to them and to their immediate situation is being discussed. The tasks usually require each member to say something about themselves. This generates a discussion of their problems and facilitates thinking about possible solutions. It is the clinician's task to make this as safe as possible. Although self disclosure can be perceived as threatening, in my long experience with groups on inpatient wards, I have found very few patients who object to engaging with the tasks or are unable to join in.

Acceptance

It is important for group members to feel that once they have disclosed some personal information, especially if this includes issues which they may perceive as unattractive to others, they are still accepted by the group. This is another powerful therapeutic factor which the clinician needs to look out for and utilise.

Feedback

All the tasks and exercises are designed to encourage interaction between group members which can generate useful feedback. For instance members make comments such as: 'I know what you mean', 'This happened to me also', 'I have been in the same situation', providing the experience of universality. Sometimes the feedback can generate a new perception of one's behaviour and contribute to behaviour change. For example a patient became agitated in the group session and shouted at another patient. At the next meeting two members he liked discussed how this affected them, saying things like 'I did not like it when you shouted last week. I felt frightened'. This led the patient to think about the impact his behaviour had on others, and to consider ways of dealing with his anger.

Personal change

Ultimately, the aim of therapy is to help group members to change patterns of their behaviour which are causing problems in their day to day life and in their dealings with other people. The example above concerned controlling anger. On the other hand, someone who finds it difficult to ask for help can learn how to approach others and receive assistance, a subdued passive person can learn to be more assertive etc.

The nature of tasks

There are a number of tasks that can be used. Tasks can be short statements or incomplete sentences the patient is asked to complete, for example:

1. One thing I would like to change about myself is…….

2. One of my strengths/weaknesses is………….

3. The person who influenced me the most was………….

4. The person who is most like me in the group is…………….

Other tasks may involve pairing patients and asking them to talk to one another about themselves for 5 minutes. The members of the pair are encouraged to ask questions and find out as much as possible in the time provided. After this we re-join the large group and members of each pair are asked to say everything they remember about the other person. The first person is then asked if the information was related correctly. This is also an exercise in listening skills.

An exercise may be organised around a theme which may be important for the group on that day. For example the therapist knows that a separation is an important issue for several patients, or because several members of the group are ready for discharge, and will be leaving soon. Then a set of questions related to separation may be discussed in the group. For example:

1. Someone I really miss is………. .

2. The hardest separation I have ever had was………..

3. I handle separation by………………..

If, for example the ward is unsettled, and some patients on the ward have been shouting and aggressive, the facilitator may decide to prepare a task relating to anger. For example:

1. When I get angry I ……………

2. When someone is aggressive towards me, I feel…………………

3. The best way to deal with anger is……………..

Advantages of tasks

Tasks provide structure and minimize anxiety, as it is clear from the outset what the group is going to do. The first part of the session resembles a classroom model with the facilitator being the teacher. I have found that patients respond to this well, and are quite keen to work on the task.

Tasks promote interest in each other. Once the group gets going, patients listen to others and are usually keen to speak. By sharing ideas and feelings the group develops cohesiveness and provides mutual support. There is an opportunity to learn from one another and to give each other feedback.

Selection of patients for group treatment

All patients on the acute admission ward are severely mentally ill, but their mental state fluctuates and so does their functioning. Some patients have been on the ward for weeks or even months, others have only just been admitted. Some patients may be manic, very thought disordered, or aggressive and therefore disruptive to the group and so not suitable for inclusion. If the group therapist is not a full time member of staff familiar with all the patients on the ward, they need the co-operation of either an assistant psychologist or nursing staff who can advise on participation. Medical notes can also be source of information.

Case study: Experience with inpatient groups on an acute admission ward

We have been running groups based on Yalom's interpersonal model on one of the Lambeth acute admission wards for the past two years. The ward is an all male, 22 bedded unit which caters for severely mentally ill clients from the London Borough of Lambeth. This is located in the inner city and is one of the most socially deprived parts of Britain. In 2005-2006 a total of 106 patients attended the group (this is about 50% of all patients admitted to the ward). A total of 48% of clients had a

diagnosis of schizophrenia or psychosis, 20% bipolar affective disorder, 8% depression, 7% dual diagnosis and 17% had other diagnoses. Groups are run weekly by a clinical psychologist and an assistant psychologist. The total of 84% of patients who joined the group treatment attended between 1-3 sessions, 12% attended between 4-6 sessions, and 4% attended more then 6 sessions.

To provide an illustration of this work, below is a brief example of a recent session:

> John had attended the group in the past, but he did not come for several weeks. He decided to attend again today. He has a problem with anger and used to become very angry and aggressive on the ward. He also became aggressive during his last group session and as it was not possible to reason with him at the time, he had to be asked to leave. Today's group task was: The person who has influenced me most in my life is……… One member of the group talked about his mother, another talked about Mohammed Ali and then it was John's turn. John said that the person who influenced him most was his father. He always did things with him and John was very close to him. Then John said that his father died about a year ago and he became tearful saying that he missed him. The group listened, and then Peter turned to John and told him that he could see a new side to him now. He found him confrontational and aggressive in the past which for him was off-putting, but could see him in a different and engaging light now. The group was invited to give feedback to John and they shared Peter's views and gave support and encouragement to John. John appeared reflective and appreciative of this feedback.

The example also shows how patients who are not well enough to attend the group one week, may benefit from attending later.

At the end of each session we ask patients to express their views about the session. Typical examples of patients' feedback include e.g. 'It is good to hear other people's experiences, to realize you are not on your own'; 'It helps you to think about things'; 'In the group people listen'; 'You get to know the others'; 'You learn to understand other people's views'. Patient feedback is generally gratifyingly positive.

Some logistics and practical issues

There are some issues that should be considered before embarking on running a group. Amongst these are the frequency of the sessions, arrangements to make sure patients are invited to attend, division of labour in organising and running groups, and arrangements for data and feedback collection. It is essential that the group sessions are backed by other ward staff. There is little chance that the group will succeed if it is not approved of by all staff and especially by ward management.

Evaluation

At this time we only have an indirect evaluation of this work available. Recently an extensive audit of patient satisfaction was implemented on three Lambeth acute adult admission wards (Hajek and DeReuck, 2007). One part of the audit was asking about satisfaction with activities including group sessions on the ward. The ward offering this type of group treatment was part of the audit, and the results were encouraging. One of the questions was: Do you find the ward activities which you attend helpful?

On the ward where interpersonal group was offered 100% of patients replied 'yes' while only 50% and 90% respectively replied 'yes' to the same question on the two other wards which offer different types of groups.

Conclusions

Group therapy has a role on acute admission wards provided it is tailored to patients' needs and to the environment. It can contribute to improving therapeutic environment on the ward, facilitate a sense of cohesion among patients, help to engage patients in the treatment process, and reduce anxiety associated with hospitalization.

References

Aveline, M. and Dryden, W. (Eds.) (1988) *Group Therapy in Britain*. Milton Keynes: Open University Press

Burlingame, G., MacKenzie, K., and Strauss, B. (2004) Small-group treatment: Evidence for effectiveness and mechanisms of change. in M. Lambert (Ed.) *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change*. New York: Wiley

Emer, D. (2004) The use of groups in inpatient facilities: needs, focus, successes, and remaining dilemmas. in W.J. DeLucia, D.A. Gerrity, C. Kalodner, and M.T. Riva (Eds.) *Handbook of Group Counselling and Psychotherapy*. London: Sage (pp 351-365)

Hajek, K. and DeReuck, T. (2007) *Patient Satisfaction Audit*. Lambeth Directorate. London: South London and Maudsley NHS Foundation Trust. Unpublished Document. Copies available on request to the author.

Lecuyer, E. (1992) Milieu therapy for short term units: A transformed practise theory. *Archives of Psychiatric Nursing*, 6, 108-116

Thomas, S.P., Shattel, M., and Martin, T. (2002) What's therapeutic about the therapeutic milieu? *Archives of Psychiatric Nursing*, 16, 3, 99-107

Walker, M. (1994) Principles of a therapeutic milieu: An overview. *Perspectives in Psychiatric Care,* 30, 3, 5-8

Yalom, I. D. (1983) *Inpatient Group Therapy*. New York: Basic Books.

Yalom, I .D. (1995) *The Theory and Practice of Group Therapy*. New York; Basic Books