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Matthew D. Mermelstein
Clarinda Mental Health Institute

Albert C. Voth
Clarinda Mental Health Institute

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By MATTHEW D. MERMELSTEIN AND ALBERT C. VOTH

Although the use of group procedures for dealing with emotionally disturbed individuals goes back centuries, it is only within comparatively recent years that it has been used extensively and intensively in our mental hospitals with an awareness of group mechanisms and the forces that make up for restoring the desirable state of psychic equilibrium. As applied today group psychotherapy is initially a concession to the fact that there are too few therapists for the many patients in our mental hospitals and that, in order to reach as many patients as possible, group techniques must be applied.

In essence, in group therapy, one therapist deals with a number of patients at the same time with discussions going on among them; the patients relating their own particular situations openly. The object of such a program is to enable the patients to express their problems to each other and gain supportive therapeutic help from each other through their open discussions. The socializing influence of such a dynamic intermingling of personalities is probably of more value and benefit than the mere gaining of insight into one's breakdown, which often seems to be the primary goal of many psychotherapeutic schools, especially in individual treatment. Dr. William Appel, President of the American Psychiatric Association, recently stated at the 6th Annual Neuropsychiatric Convention in Little Rock, Ark., that the essence of psychotherapy is not so much to achieve insight but rather to enrich the individual with the satisfactions of living. At that same meeting Dr. Jules Masserman stressed the role of psychotherapy as the attempt to restore the individual to his own group level, functioning adequately and productively, with purposeful behavior.

There are many different kinds of group therapy approaches, possibly as many as there are therapists conducting such treatment. The remarks in this paper are limited to a specific program which has been in operation at the Clarinda Mental Health Institute, Clarinda, Iowa for the past five years. The round-table procedure used here was introduced after several of the Institute's staff members observed its operation at the Missouri State Hospital

at St. Joseph, Missouri, under the direction of Dr. W. McCann (McCann & Almada 1950). In this procedure an initial group of patients, preferably not more than seven, is selected from a ward to serve as nucleus or table group. This selection can be made by the therapist alone or with the collaboration of the ward physician, or even in conference with the entire ward population. The therapy procedures and aims are then explained to the table group and eventually to the entire participating ward. For the table group, patients are at first selected who are most likely to participate in the discussions, but diagnostic homogeneity is not necessarily desirable. That-is-to-say, patients with different diagnostic labels can meet together. The only dichotomy made is that of sex differences.

Sessions are held three times weekly. At each session a microphone connected to a tape recorder, in full sight of the patients, is placed on a table around which are seated the members of the nucleus group. The patients of this group then discuss with each other as extensively as they can, the care, the circumstances, nature, and meaning of their respective illnesses and their presence in the hospital. This discussion continues for 30 minutes and is recorded with the patients' full knowledge.

At the beginning of the next following session the recording of the previous session is played back to the patients and then a further 30 minutes discussion is recorded for the play-back of the next session.

During group discussions the entire ward population, excepting excessively disturbed patients, is present. Although discussions are usually limited to the table group, questions from the listening periphery group are sometimes entertained commensurate with desirable decorum. It is important during the recording session that the therapist remain silent as much as possible, making it understood to the patients in advance that the discussions represent their free untrammeled privilege to talk their difficulties through with each other. They are assured that the recording is solely for the purpose of review in the play-back, subject to no outside scrutiny and is erased after each play-back. Occasionally a question may be directed to the therapist, but even then, sometimes, he may do well to redirect the question back to the group for an answer.

Between each recording and play-back session the therapist meets with members of the group individually or collectively, without the presence of the listening group, to elaborate on what has been said in the recording session and to point out to the discus-

sants further fruitful directions that might be taken in the coming session. These interim meetings with the table group are, one might say, in the form of briefings for the next general session, and in themselves serve an important aspect of the therapeutic work in that the therapist, through them, becomes the active influence for the whole procedure. During briefing sessions questions of recovery of some particular patients are considered. If in the opinion of the therapist or members of the group some patient in the table group merits a transfer to a convalescent ward, the matter is brought to a vote. With every such vote, affirmative or negative, members of the group are asked for reasons for their decisions. Upon an affirmative decision for transfer, the central table group is asked to elect a new member from the peripheral or listening group to replace the outgoing member. Here, again, the therapist sometimes has to exercise his judgment in a briefing capacity. It has been found that the patients of the table group often have good and correct discernment of who among them has progressed to a convalescent stage and who in the peripheral area may be most ready to actively participate in the table discussion. The convalescent ward is represented to the patient as a step toward release from the hospital and offers a strong motivational element toward active group participation and in the therapeutic process in general. As a matter of practice it is desirable from time to time to keep patients, who still remain on the treatment ward, informed of progress made by transferred patients and especially of their convalescent return home. This continuity between convalescent status and active treatment of patients is also maintained by further group sessions essentially similar to those already described but somewhat less formal and limited to two sessions per week. They are conducted on the convalescent ward and tie up with the treatment program for more chronic patients in a manner later to be described.

It is desirable for the therapist to maintain progress records of each table patient and for each session. These records need not necessarily be extensive for each session but should be detailed enough to furnish material for a satisfactory summary of the patient's progress for inclusion in the permanent record files upon the patient's transfer from the group.

Patients who are new to the table are sometimes at first quite hesitant to participate actively in the conversations, or they keep their voices at a weak, timid volume. Such patients are not too quickly dismissed from the active table group but are given re-

peated, friendly encouragement to speak up. Such demands on them to give strength and clarity to their expressions for the sake of good recordings frequently has been noted to generate self-confidence and hence affect good therapeutic influence. Slow progress is no ipso-facto reason for dismissal from the discussion group and apparent chronicity or shrinking timidity or seclusiveness is no foregone evidence that group therapy can not be beneficial. Since an entire ward participates in this form of therapy is is found ideally desirable that the ward be maintained exclusively as a therapy ward without too much population turn-over except transfers to the convalescent ward. We have also found it necessary that the aides in charge of the ward be indoctrinated in the purpose of the therapeutic procedures and be in sympathy with them. Patients frequently continue their discussions with each other in smaller more intimate groups after the formal sessions are closed and thus develop a community of interest that makes for good ward morale and discipline. The ward supervisor and aides necessarily become essential parties to this. The atmosphere in the group is a permissive one, but also one of individual responsibility for progress. Response pressure comes from the group members themselves and, in essence, this may be equated with those social pressures to which the patient will return when he leaves the hospital.

Many patients share similar delusional thoughts and problems. This community of aberrant experiences comes as quite a surprise to many of them. The common-place that it is much easier to see the mote in the brother's eye than the beam in one's own eye holds amazingly true for psychotic patients in the group setting. This negative myopic tendency, however, can also assume a positive capacity to recognize the improvement that allows the casting of an affirmative vote to rightly send the other patient to the convalescent ward. One of the most outstanding values of the recorded group discussions, we believe, lies in the objectifying impact of the otherwise autistic and hence, to the patient, unrecognized delusional character of his expressions. On first impact a patient may often declare that what he hears on the record is not his own voice, or he may be amazed that he made such statements. In contradistinction he usually correctly recognizes the voices of the other members of his group and recalls their previous remarks. Eventually he may come to hear himself as others hear him, sometimes with rather dramatic results.

Most of the acutely ill patients with psychoses of so-called psychogenic origins, who are found suitable for group therapy in our hospital, have also at some time received electroshock or insulin therapy, or a combination of both, during the course of their stay in the hospital. Therefore, group therapy must not be solely credited for improvements or recoveries that occur. It serves as a differential treatment and a carry-through, so-to-speak, after the initial necessities for shock and insulin treatments have been served, and in most instances runs concurrently with such physical treatments while they are in progress.

The impact of group therapy becomes more pronounced and telling in such cases where physical forms of treatment have either not shown lasting effects or have failed entirely. This points up the special problem of delayed recovery and the semi-chronic and chronic patient. To meet this problem we have found it practicable and, indeed, desirable on our convalescent wards to incorporate some of our long-term group therapy for chronic and semi-chronic patients with the therapy conducted among convalescent patients who, in most instances, have already had considerable group activity on the acute treatment wards before coming to the convalescent wards. Contrary to first thought, such an arrangement actually seems to stimulate convalescent patients toward continued improvement and at the same time acts as a catalytic impulse among the more chronic ones. Time does not permit in this paper for detailed description of our group therapy program with chronic and semi-chronic patients. In summary, at the present writing, we have six such groups of about twenty patients in each group meeting twice weekly under the direction of four different therapists. These sessions are essentially the same as those already described for acute patients with the exception, however, that the membership of active discussants at the table may at times vary more frequently and extensively. This is necessitated by the fact that under the long-term duration of a chronic group program the opportunity to actively participate must be extended to as many as possible. The reticence of some chronic patients sometimes holds them in silence for long periods before they show willingness to talk. Once such willingness is shown, however, it is usually enthusiastically welcomed on the spot by the more active discussants through an immediate invitation to the table. Duration of illness is in itself no criterion for exclusion from the therapy group. Some of our participants have been in the hospital for as long as fifteen years.

The results of our group efforts have been encouraging. Not infrequently we have seen patients released on trial visit to their homes and eventually discharged as recovered when sober cautious prognostic appraisal had warranted no such hopes, and physical forms of treatments had been disappointing. As is to be expected, far more improvements and recoveries occur among patients where the illness is of recent or relatively recent onset. Since the treatment program for the more acute or semi-acute patients in our hospital is necessarily somewhat in the form of an urgent total push, group psychotherapy becomes an adjunctive activity. Improvement and recovery statistics cannot, therefore, be presented here in the critical sense one should expect from a more controlled setting. However, progress of one group series will here be briefly given: In this series 140 women passed through the group program in the course of approximately a year and a half under the continuous direction of one therapist, beginning November 1949. By December 1, 1951, 118 (84.3%) had at some time been released on trial visit. Of these, 30 had returned and 11 again released thus leaving (70.7%) still outside of the hospital. A year later a perusal of this same series of 140 patients showed that 125 (89%) had at some time been on trial visit, 44 had at some time returned and 31 again released, leaving a net of 80% outside. Since then the number of patients, of this particular series, living outside of the hospital has fluctuated between approximately 75 and 80 percent, with a maximum release of 90%. The composition of this group was about evenly divided between manic-depressives and schizophrenics, with manic-depressives furnishing the greater number of returns to the hospital. Returned patients were again taken into group therapy and sometimes given an additional course of electroshock or insulin therapy. When this series was started in 1949 approximately twenty per cent of the included patients were counted as semi-chronic, in whom physical forms of therapy had been discontinued and the stay in the hospital had become prolonged.

Our work with chronic patients is still somewhat in an exploratory stage. It has, however, been definitely rewarding in that it often serves to stem the patient's drift toward greater chronicity and deterioration. A few, approximately 15 to 20 per cent, have been released from the hospital. Many of those remaining have moved to more favorable and open wards with ground privileges. Better socialization, pride in personal appearance, expanded interests, and ability and willingness to perform daily work in the

hospital have all been consistent and lasting consequences. Group activities have apparently acted as a leaven in the hospital population, attested to by the repeated spontaneous requests from patients to be allowed to attend group sessions. The resultant waiting lists from such requests and the pressing needs created by the never-ending influx of new patients would seem to delineate the group approach as the method of choice in psychotherapy, at least for large mental institutions.

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Department of Psychology
Clarinda Mental Health Institute
Clarinda, Iowa