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Brief Heterogeneous Inpatient Groups: A Process-Oriented Psychoeducational Model

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A Process-Oriented Psychoeducational Model

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Each person whose signature appears below certifies that this doctoral project, in his opinion, is adequate in the scope and quality as a doctoral project for the degree of Doctor of Psychology.

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TABLE OF CONTENTS

LIST OF FIGURES

Figure Page

LIST OF TABLES

Table Page

ABSTRACT

Brief Heterogeneous Inpatient Groups:
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In the U.S., we currently have an increase in admissions to psychiatric hospitals and a lack of research exploring inpatient group psychotherapy. Diagnostically homogeneous therapy groups outperform therapy groups with mixed symptoms, however, due to managed health care, psychiatric hospitals typically run brief duration, diagnostically heterogeneous groups. A review of the research literature was conducted in order to locate empirical studies that could offer treatment recommendations regarding how to facilitate brief duration, diagnostically heterogeneous inpatient psychotherapy groups. Although this review revealed little information about this specific type of group, common factors from inpatient studies were extracted. Based on a synthesis of these studies, a cross-sectional, process-oriented psychoeducational treatment model is suggested.

Chapter 1

Introduction

Clinical Importance of Problem

Increase in psychiatric hospital admissions. National surveys showed declines in the number of patient residents in state psychiatric hospitals since the 1950s and in the number of patient admissions since the 1970s. These declines were attributed to the emerging use of psychotropic medication and the development of alternative or liberating forms of non-institutionalized treatment (i.e., more community-based services were developed; Manderscheid & Atay, 2009). However, annual data from the Center for Mental Health Services, the national Survey of Mental Health Organizations, and the National Association of State Mental Health Program Directors Research Institute all suggest a reversal in these trends (CMHS, 2004; Manderscheid & Atay, 2009; NRI, 2005; SMHO, 2005). Nationwide, states showed a 21% increase in state psychiatric hospital patient admissions from 2002-2005. In addition, there was a nationwide increase of 1% for patient residents in state psychiatric hospitals between 2002 and 2005 (CMHS, 2004; Manderscheid & Atay, 2009; NRI, 2005). This 21% increase marks the first increase in state psychiatric hospital patient admissions since 1971. In addition, although there was only a 1% increase in patient residents, this marks the first increase in state psychiatric hospital patient residents since 1955 (Manderscheid & Atay, 2009).

The 11 states that showed the greatest increases, including California, were surveyed by phone in order to better understand the changes in these trends. State mental health agency staff attributed these changes to the number of forensic admissions, an increase in patients diagnosed with schizophrenia and affective disorders, and also a lack

of community resources (Manderscheid & Atay, 2009; SMHO, 2005). This was consistent with the annual report which found increases in the number of admissions with schizophrenia (23%) and affective disorders (16%) between 2002 and 2005 (CMHS, 2004; Manderscheid & Atay, 2009; NRI, 2005). Schizophrenia and affective disorders represent the most commonly seen diagnoses in state psychiatric hospital admissions and residents (Manderscheid & Atay, 2009). In addition, perhaps further contributing to the increase in admissions and residents, there appears to be a decline in the availability of housing and community-based care. Data also shed some light on state trends; since the year 2000, California showed the largest increase in admissions and year end residents in state psychiatric hospitals. From 2000 to 2005, the number of admissions in California state psychiatric hospitals increased by 109% while the number of yearend residents increased by 2% (CMHS, 2004; Manderscheid & Atay, 2009; NRI, 2005).

Overall, these national trends show an increase in state psychiatric hospital patient admissions, patient residents, and patients diagnosed with schizophrenia and affective disorders (Manderscheid & Atay, 2009; CMHS, 2004; and NRI, 2005). However, there appears to be very limited research available regarding admission trends for the acute inpatient ward or unit as found in private psychiatric hospitals and Veteran Administration hospitals. However, the national trends discovered for state psychiatric hospitals by Manderscheid & Atay (2009), suggest that inpatient facilities in general may need to be clinically prepared to treat larger amounts of patients with mixed symptoms (Manderscheid & Atay 2009; CMHS, 2004; and NRI, 2005). Therefore, research in this area may prove beneficial.

Lack of inpatient psychiatric research. Although group therapy has long been a primary part of treatment for psychiatric inpatients (Kosters, Nachtigall, Burlingame & Strauss, 2006; Strauss, & Burgmeier-Lohse, 1994; Tschuschke, 1999), the majority of inpatient psychiatric research is conducted in Germany (Kosters et al., 2006; Strauss, 1992). In addition, little is known about overall effectiveness (Kosters et al., 2006). One reason for our limited knowledge is because Germany has a very different health care system than the United States, rendering group therapy models incomparable. However, similarities between the German and U.S. systems do exist. For example, there are similarities with regard to residential populations and patients with diagnoses of severe psychotic disorders (Kosters et al., 2006).

A second reason for our limited knowledge regarding inpatient treatment effectiveness may be due to the complex nature of group treatment. This complexity makes conclusions regarding effectiveness very difficult (Fuhriman & Burlingame, 1994; Kosters et al., 2006). This may be even more valid of inpatient groups, due to a number of treatment and contextual factors interacting to influence patient outcomes (Kosters et al., 2006). Conducting rigorous research on non-diagnostically specific inpatient psychotherapy groups creates overwhelming methodological problems (Pollack, Harvin & Cramer, 2010; Yalom, 1983).

A third reason for our limited knowledge stems from a lack of controlled studies. Research involving controlled studies is difficult to implement in inpatient settings because of ethical concerns (i.e., who gets the treatment versus who is placed in the control group). This creates an over reliance on pre- to post-comparative research. Therefore, systematic reviews regarding the effectiveness of inpatient groups are lacking

(Kosters et al., 2006). “There is a paucity of program evaluation research of hospital-based group psychotherapy programs,” (Fitzsimmons et al., 2008, p. 177). Pollack, Harvin, and Cramer (2010), also agreed that there is a lack of research on inpatient groups in general.

Kosters et al. (2006) examined inpatient group therapy effectiveness in a meta-analysis of 70 studies. These studies were a combination of controlled, pre and post studies that dated from 1980-2004, while also considering the location of studies prior to 1980. This study found that half of the pre-1980 studies on inpatient group therapy were conducted in the U.S. and only 18% of post 1980 studies were conducted in the U.S. This suggests that in recent decades, there has been a dramatic decrease in inpatient group effectiveness research in the U.S. This decrease may be due to the affects of managed behavioral health care which has greatly reduced the duration of inpatient stay and the types of treatment offered in the U.S (Burlingame, MacKenzie, & Strauss, 2004; Kosters et al., 2006).

The current lack of research exploring inpatient group psychotherapy effectiveness may be attributed to a lack of research conducted in the U.S. (Burlingame, MacKenzie & Strauss, 2004; Kosters et al., 2006), the complex nature of group therapy in general (Pollack, Harvin, & Cramer, 2010; Yalom, 1983), and the influence of managed health care (Burlingame, MacKenzie, & Strauss, 2004; Kosters et al., 2006). In addition, the majority of inpatient psychiatric research is conducted in Germany. More U.S. research is needed because the differences between the German and U. S. health care systems render group therapy models incomparable (Kosters et al., 2006; Strauss, 1992). Also, drawing conclusions about inpatient treatment effectiveness can be difficult due to

the complex nature of group therapy, which would likely increase validity in the inpatient setting. There also appears to be little knowledge regarding inpatient effectiveness due to a lack of controlled studies and an over-reliance on pre-to-post comparisons (Fuhriman & Burlingame, 1994; Kosters et al., 2006). Since 1980, the number of U.S. studies examining inpatient treatment effectiveness has largely decreased due to changes in health care influencing the duration of patient stay and types of treatment offered (Burlingame, MacKenzie, & Strauss, 2004; Kosters et al., 2006). They current study aims to counter this decrease by offering a more relevant and timely group model.

Managed health care. Managed health care arose from the need to provide efficient quality care in response to the increasing costs of health care. Therefore, clinicians now have pressure to not only perform high quality care but to do so in a very time limited manner (Budman & Steenbarger, 1997). The major changes in health insurance have created challenges for managed mental health care services because brief problem-focused treatment with proven efficacy has now become the standard (Daniels, 1998). Short-term group therapy was traditionally defined as having twelve to fifteen sessions; however, due to changes in health care, inpatient stays typically last three to five days resulting in patients attending three to five group therapy sessions (Bilynsky & Lyke, 2001). This brings challenges to the treatment of chronic mental illness which often calls for long-term treatment (Daniels, 1998). Furthermore, the push for clinical efficiency has favored the use of group over individual therapy because services can be provided to more patients per clinical hour (Scutaro, 2004). The demand for brief group therapy in the inpatient setting means that psychologists are faced with the challenge of leading groups that are in constant flux (Bilynsky & Lyke, 2001).

A survey of behavioral health maintenance organizations (HMOs) by Taylor et al. (2001) revealed that HMOs are likely to increase the use of time-limited group therapy and decrease the use of individual treatment. These changes in health insurance and subsequent treatment approaches may also be adversely influencing the composition of therapy groups. For instance, in most inpatient settings, practical considerations dictate that patients with various diagnoses are placed in the same group (Brabender & Fallon 1993; Erickson, 1986). It is typically assumed that the unity surrounding the common experience of diagnostically homogeneous groups fosters expedited identification, trust, and cohesion among group members. However, in today's behavioral health care environment, therapy groups are composed of members with a wide range of symptoms and problem areas. Therefore, groups that range in composition can create a clinical dilemma (Scaturo, 2004).

Burlingame et al. (2003) conducted a meta-analysis exploring the differential effectiveness of 111 experimental and quasi-experimental studies that were conducted in the previous 20 years. Results from this study showed that clients in homogeneous groups outperformed those in groups with mixed symptoms. It was also found that outpatients improved more than inpatients. According to Yalom (1995) "Homogeneous groups jell more quickly, become more cohesive, offer more immediate support to group members, are better attended, have less conflict, and provide more rapid relief of symptoms" (p. 255). Inpatient settings have also taken note of the importance of diagnostic homogeneity. For instance, some institutions will even attempt to organize mixed unit groups in order to achieve more homogeneity among members of the group in terms of level of functioning or symptomatology (Brabender & Fallon, 1993). In most cases,

groups are designed to focus on specific skills for relatively high functioning homogeneous participants. This can be problematic because most groups may even end up excluding the participants who are struggling with more severe forms of mental illness (Simon, 1994).

Therefore, research appears to support the theory that diagnostic homogeneity is ideal in order to achieve the greatest treatment gains. However, in most inpatient settings, diagnostically homogeneous therapy groups become impractical (Brabender & Fallon, 1993). Interestingly, most studies appear to be paying little attention to the diagnostic composition of inpatient therapy groups. For example, Kosters et al. (2006) conducted a meta-analysis of 70 inpatient group therapy studies. Of these studies, only 12 mentioned the diagnostic composition of the group. The majority of studies, 46, were not explicitly clear regarding group composition. Inpatient psychotherapy groups now have an abbreviated time frame, diagnostic heterogeneity and revolving door membership. This reality creates a need for group leaders to alter the format of traditional inpatient group psychotherapy (Bilynsky & Lyke, 2001). Due to the decrease in inpatient duration of stay, lengthy inpatient group models may no longer be the most appropriate form of treatment (Talbot, 1998). "Therefore, new models of inpatient group therapy for acute inpatients that can be accomplished within the context of brief inpatient and partial hospital stays need to be developed."

The current state of inpatient psychotherapy groups has been greatly influenced by the changes in managed health care (Bilynsky & Lyke, 2001). These groups are now characterized by increasing numbers of diagnostically heterogeneous members (Scaturo, 2004). Group composition ranges in severity of pathology from schizophrenia to affective

disorders (Manderscheid & Atay, 2009). The push for efficient quality care has also created rotating group membership where the composition of psychotherapy groups changes on a daily basis. This creates a challenging and demanding situation for clinical treatment because nearly every group conducted consists of a different subset of patients and diagnoses (Bilynsky & Lyke, 2001; Manderscheid & Atay, 2009). In addition, there is a lack of research in the U.S. exploring treatment approaches for such groups (Burlingame, MacKenzie & Strauss, 2004; Kosters et al., 2006). There is a need to develop new group therapy models for the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group (Bilynsky & Lyke, 2001; Manderscheid & Atay, 2009; Talbot, 1998).

Aim of Current Study

In the U.S., we currently have an increase in admissions to psychiatric hospitals and a lack of research exploring inpatient group psychotherapy (Fitzsimmons et al., 2008; Kosters et al., 2006; Manderscheid & Atay, 2009). Diagnostically homogeneous therapy groups outperform therapy groups with mixed symptoms, however, due to managed health care, psychiatric hospitals typically run brief diagnostically heterogeneous groups (Brabender & Fallon, 1993; Burlingame et al., 2003). Inpatient psychotherapy groups of this nature are also consistent with the current author's clinical observations (see Appendix). A review of the research literature was conducted in order to locate empirical studies that could offer treatment recommendations regarding how to facilitate open-ended, brief in duration, diagnostically heterogeneous inpatient psychotherapy groups. The literature revealed little information about this specific type of group. Therefore, this current study aims to offer treatment recommendations on how to facilitate a

diagnostically heterogeneous psychotherapy group demonstrated through a synthesis of the research literature in the area of inpatient group psychotherapy. The aim of this paper is to offer a shorthanded, guiding framework towards the development of a treatment model for the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group (Brabender & Fallon 1993). The proposed treatment model will be based upon an integration of the theoretical constructs of process-oriented psychotherapy and psychoeducation.

Chapter 2

Review of Literature

History of Group Psychotherapy

The first known application of group therapy appears to have occurred in 1905 when an American physician, John Hersey Pratt, treated tuberculosis patients in a group format. The idea of group therapy later gained some momentum as an efficient and economic manner in which to treat groups of patients within psychiatric facilities (Barlow, Burlingame, & Fuhriman, 2000). Although the reasons were at first economical, the therapeutic effects became apparent as early as the 1920s. In perhaps one of the first studies on group treatment, patients were asked what typically helped them solve their problems (Lazell, 1921). It was these "talks" that the majority of patients later referred to as the beginning of their recovery (Lazell, 1968, p. 168). Interestingly, the grouping of patients according to symptoms also began early on. For instance, Lazell noted that patients were grouped according to hallucinations, paranoia, depression and suicide. Lazell also observed that the benefits of group treatment included the experience of universality and the retention of information. In fact, one of the sessions focused on the explanation of hallucinations and delusions. Lazell (1921) concluded that "institutions for the insane should be changed to institutions for instruction" (p. 179).

The shortcomings of psychiatric facilities have been noted since the 1930s. Marsh (1935) noted that few people could afford a private psychiatrist and that the psychiatric facilities of the time needed attention. He went on to argue that group therapy had advantages over individual therapy because transference could be broken more easily and the opportunity for education was greater. He advocated for the use of group treatment in

psychiatric facilities and that treatment should have an educational rather than a medical process. Lazell and Marsh's psychoeducational method was groundbreaking in the treatment of mentally disordered inpatients (Barlow, Burlingame, & Fuhriman, 2000).

By the 1940s and 1950s, Foulkes (1946) and Bion (1952) offered psychoanalytic theories regarding the intra-psychic processes that were at work during group treatment. Although these theorists were certainly instrumental to more modern day conceptualizations of group therapy, some have since argued that the psychoanalytic approaches of the 1950s were geared towards outpatient group therapy where the distinction of the inpatient adaptation and setting was largely lost (Brabender & Fallon 1993).

The 1960s began to distinguish the inpatient group as more of a unique entity from the outpatient group needing its own specific approaches (Brabender & Fallon, 1993). Group therapy with hospitalized patients began to receive a variety of therapeutic approaches, including: psychoanalysis, psychodrama, nondirective and milieu orientations (Barlow, Burlingame, & Fuhriman, 2000). It was noted that inpatients could benefit from group therapy by learning to express their feelings and take accountability for their actions. This in turn helped inpatients with things such as isolation, morale and interpersonal relations. However, there was still the belief that groups with mixed symptoms should be avoided, "Psychoneurotics, antisocial personalities, alcoholics and the overtly insane should be in separate groups," (Frank, 1963, p. 713). Barlow, Burlingame, and Fuhriman (2000) reviewed several comparative studies from the 1960s, most of which were conducted by Mann and Rickard. These studies were criticized for

being based mostly on institutionalized patients in which there was a lack of equivalent comparison groups.

Barlow, Burlingame, and Fuhriman (2000) also reviewed several studies from the 1970s, most of which were conducted by Emrick (1975) and Lieberman (1976). These studies, looking at a mixture of outpatient and inpatient group therapy, which began to show the efficacy of groups over controls. Results were comparable to individual treatment. Interestingly, researchers began to note that certain types of treatment appeared to be more effective with certain types of disorders, perhaps hinting at the increasingly popular idea of 'patient matching'. Also of interest, the emergence of a heterogeneous treatment orientation began to appear more commonly (Barlow, Burlingame, & Fuhriman, 2000).

Barlow, Burlingame, and Fuhriman, (2000) found that studies from the 1980s, most of which were conducted by Kanas (1986) and Toseland and Siporin (1986), began to reveal clearer connections between group therapy processes and specific outcomes. In addition, there was an increase in attention being paid to matching theoretical orientation to specific diagnoses. Also, studies began to include several comparison groups. Studies from the 1990s continued with the emphasis of comparison groups and treatment matching (Barlow, Burlingame, & Fuhriman, 2000). Group therapy in the 1990s began to develop and apply treatment protocols to specific diagnoses, settings and orientations (Burlingame, Fuhriman, & Moiser, 2003). In addition, more cognitive behavioral approaches began to emerge (Barlow, Burlingame, & Fuhriman, 2000).

Since the early studies of Lazell and Marsh, group therapy has experienced several adaptations in order to meet the changing needs of clinical practice (Yalom,

2005). We now have a convincing body of research evidence demonstrating that group therapy is a very effective form of psychotherapy. According to Yalom (2005), the therapeutic change that takes place during group therapy is a process that occurs through an interplay of human experiences called "therapeutic factors," (p. 1). Yalom has defined a total of eleven therapeutic factors; installation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors.

Inpatient diagnoses. As discussed earlier, Kosters et al. (2006) conducted a meta-analysis that examined inpatient group therapy effectiveness in 70 controlled and pre and post studies that dated from 1980 to 2004. This study provides insight regarding common diagnoses that are seen in inpatient settings. The most common diagnoses represented in these studies were mixed, schizophrenia/psychosis, post-traumatic stress, psychosomatic, mood, anxiety and personality disorders respectively (Kosters et al., 2006). Burlingame et al.'s 2003 meta-analysis, which explored the differential effectiveness of 111 studies that were conducted in the previous 20 years, sheds light on the diagnostic composition of therapy groups. Some common diagnoses seen from these 111 reviewed studies were anxiety, depression, eating disorders, antisocial and thought disorders. However, this study looked at both inpatient and outpatient group therapy studies. Therefore, these diagnoses may not be the most accurate reflection of common diagnoses seen strictly at the inpatient level. However, when taken in conjunction with the meta-analyses by Kosters et al. (2006) and Burlingame et al. (2003), both appear to

agree on the presence of psychosis/thought and mood/anxiety disorders as some of the more prevalent diagnoses at the inpatient level.

Although the meta-analysis by Kosters et al. (2006) shed light on the presence of personality disorders in the inpatient setting, a study by Simon (1994) sheds a brighter light in this area. A study of 664 patients who met criteria for personality disorders were found to have a more extensive history of psychiatric inpatient treatment than any other diagnosis. It has been estimated that 19% of psychiatric inpatients meet criteria for Borderline Personality Disorder. Approximately 50% of psychiatric inpatients meet criteria for some type of personality disorder, while 63% are of the borderline type (Simon, 1994; Widiger & Frances, 1989). Psychiatric hospital populations may contain a greater number of borderline personality disorders in comparison to other personality disorders due to greater frequencies of self-destructive behaviors committed relative to other personality disorders. For instance, it has been estimated that 70-75% of borderlines have a history of at least one self-injurious act (Clarkin et al., 1983; Cowdry, et al., 1985; Simon, 1994). Therefore, in light of the findings by Simon (1994) and Widiger and Frances (1989), borderline personality disorder may be one of the more commonly seen diagnoses at the inpatient level.

A recent study by Angstman and Schuldberg (2009), examined a diagnostically heterogeneous population at a state psychiatric hospital in a western American state. Although the focus on this study was on quality of life for inpatients, interestingly, participant diagnoses consisted of: schizophrenia spectrum disorders, depression, bipolar, substance abuse and personality disorders, respectively. Although this study was isolated

to a western state, participant diagnoses were consistent with national trends and the aforementioned studies regarding commonly seen inpatient diagnoses.

In sum, national trends suggest that next to schizophrenia, affective disorders are the most prevalent diagnoses for patients in state psychiatric hospitals (Manderscheid & Atay, 2009). As stated, the meta-analysis by Kosters et al. (2006) and Burlingame et al. (2003) both appear to agree on the presence of psychosis/thought and mood/anxiety disorders as some of the more prevalent diagnoses at the inpatient level. In addition, Simon (1994) and Widiger and Frances (1989) all suggest that borderline personality disorder may be one of the more commonly seen diagnoses at the inpatient level. Yalom (2005) also noted that there is a heterogeneity of pathology present within the contemporary psychiatric inpatient unit. He noted a variety of diagnoses which included psychosis, borderline personality disorder and affective disorders. Therefore, studies seem to suggest that within the heterogeneity of pathology present, some of the most commonly agreed upon diagnoses seen in inpatient psychiatric hospitals may include: psychotic spectrum, mood and borderline personality disorders.

Inpatient treatment approaches. The meta-analysis of 70 inpatient studies from 1980 to 2004 by Kosters et al. (2006), found that the most common theoretical orientations were cognitive behavioral therapy, psychodynamic, unknown, and eclectic, respectively. In addition, the Burlingame et al. meta-analysis of 111 studies on inpatient and outpatient group psychotherapy published in the last 20 years, found that the most common approaches were CBT, behavioral, psychodynamic and eclectic, respectively (Burlingame et al., 2003).

Burlingame et al. (2003) went on to elaborate that behavioral orientation groups were more effective than eclectic orientation groups. The behavioral orientation groups were likely composed of patients suffering from similar problems (i.e., homogeneous in composition) and the group was conducted using a manual. Burlingame et al. described the behavioral orientation or manual approach as one that provided session by session structure, was psychoeducational, and interaction was driven by the therapist and the topic. The effectiveness of highly structured session by session psychoeducational groups suggests that obtaining information and practicing relevant behaviors may be necessary in order to achieve treatment gains. However, these factors more commonly coincide with outpatient rather than inpatient groups. This study concluded that behaviorally-oriented, homogeneous outpatient groups showed the greatest client improvement (Burlingame et al., 2003).

Ludgate et al. (1993) suggest a collaborative approach and Socratic Method for inpatient group therapy. This provides a forum where patients are encouraged to participate in their recovery by bringing topics for the agenda, identifying and challenging their own automatic thoughts and schema and, generating pros and cons to self-identified options. This approach counteracts the passivity and dependency that can be fostered by the hospital environment.

The meta-analyses conducted by Kosters et al. (2006) and Burlingame et al. (2003) agreed that common inpatient group psychotherapy approaches include: cognitive behavioral therapy, psychodynamic and eclectic, respectively. Although not widely represented in the literature, others have suggested a collaborative approach. This encourages patients to be engaged in their recovery by bringing agenda topics,

challenging their own automatic thoughts and learning to explore options by generating pros and cons (Ludgate et al., 1993). In terms of efficacy, Burlingame et al. (2003) found that a behavioral approach which is highly structured and psychoeducational may be most effective. However, this approach applies best to homogeneous outpatient groups. This finding from 111 studies from the previous 20 years leaves many questions about an effective approach for a heterogeneous, acute inpatient, brief duration psychotherapy group.

Interestingly, Lazell (1921) noted that the majority of psychiatric inpatients reported that "talks" were the beginning of their recovery (Lazell, 1968, p. 168). In addition, he observed that the benefits of group treatment included the experience of universality and the retention of information. He even concluded that "institutions for the insane should be changed to institutions for instruction" (Lazell, 1921, p. 179). Marsh (1935) advocated that group treatment in psychiatric facilities should have an educational process (Marsh, 1935). Others have since added that Lazell and Marsh's psychoeducational method was groundbreaking in the treatment of mentally disordered inpatients (Barlow, Burlingame, & Fuhriman, 2000). The more recent studies on inpatient group therapy conducted by Kosters et al. (2006), Burlingame et al. (2003), and Ludgate et al. (1993) have explored a wide range of inpatient treatment approaches. Overall, the commonalities that all of these treatment approaches appear to share include aspects of process and psychoeducation.

Process-oriented psychotherapy. Process-oriented psychology (or 'process work') is a way of working with the designs and structures of the conscious human experience. In other words, process-oriented psychology is a way to study how an

individual subjectively organizes and perceives their conscious experience. The term process can be defined as the observer's perceptions of the movement of their own experience. There are aspects of a person's process for which they can and cannot identify with; for example, aspects of an individual's secondary process (i.e., aspects of their experience which may not be identified with by the self) may influence their primary process (i.e., aspects of their experience for which they have self-awareness) (Szymkiewicz-Kowalska, 1999).

Like individuals, in group psychotherapy, there are aspects of the group process that members do and do not identify with (Dworkin, 1990; Szymkiewicz-Kowalska, 1999). However, individuals are able to gain awareness and fully conceptualize 'here-and-now' interactions through the facilitation of processing (Slife et al., 1989). One way a group facilitator can determine the issues around which members are identifying with is to encourage group members to share their points of view while listening for themes. This facilitative response is called 'sorting'. 'Sorting' allows the group leader to structure the group topics or the emerging themes to better meet the needs of group members, such as the un-identified group processes (i.e., intrapsychic, interpersonal and group-as-a-whole; Szymkiewicz-Kowalska, 1999). This appears to be especially pertinent to the diagnostically heterogeneous group which calls for an approach that will apply to a wide range of individuals and interpersonal processes.

In addition, it is important to consider that in group psychotherapy, an individual's process can occur in a three dimensional manner with respect to their relationships within the group. For example, process has also been defined as "the nature of the relationship between individuals who are interacting with one another" (Ettin &

Vaughan, 1987, p. 178; Yalom, 1985). Others have elaborated by stating that this relationship can have a threefold aspect because it can be between the individual and himself/herself (i.e., intrapsychic process), between group members or group members and the group leader (i.e., interpersonal process), or between the psychotherapy group as a collective whole (i.e., group-as-a-whole process; Ettin & Vaughan, 1987; Rice, 1969). In regards to interpersonal interactions, otherwise known as interpersonal process, between group members, and also group members and the group leader, quality process comments on behalf of the group leader offer some explanation of 'here-and-now' interpersonal relationships (Slife et al., 1989; Yalom, 1983). It seems reasonable to assume that quality process comments from the group leader that offer 'here-and-now' explanations would benefit not only interpersonal processes but also intrapsychic and group-as-a-whole processes.

Process-oriented group psychotherapy is distinctly different from content-based or purely cognitive psychotherapy. For example, the content of a group may be about the current struggles of the group members. Process can be seen as a person's ability to step back from the content of a struggle and reflect upon one-self and the group (Slife et al., 1989). The process of the group would then be about how the group members are pursuing a solution or relief to those struggles. Therefore, group process can be direct or reactive on the part of the therapist, yet still not isolated to the content (Brabender & Fallon, 1993). The process may then be more flexible and fluid within the group dynamic and the movement of the group interpersonal relationships, even with heterogeneous diagnoses, as the process is to help with the struggles, rather than only defining the content of the struggles. In addition it seems reasonable to assume that encouraging and

allowing time for processing may increase one's ability to self reflect and then return to the content of their struggle with a clearer perspective of how to relieve that struggle.

According to Yalom (2005), the therapeutic change that takes place during group therapy is a process that occurs through an interplay of human experiences called "therapeutic factors," (p. 1). As described earlier, Yalom has defined a total of fourteen therapeutic factors; installation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, self-understanding, self disclosure, guidance and existential factors. All of these factors are essential to the processing of human experience.

Daniels (1998) summarized Yalom's (2005) therapeutic group factors as they relate to process-focused therapy, such as: (a) universality, or helping the patient to feel understood because others are experiences their symptoms as well; (b) altruism, which can be considered to be an action that is helpful to the leader or other group member; (c) acceptance/cohesion, an increased sense of unity, stability, and safety within the group; (d) self-disclosure, such as sharing personal information that lead to increased cohesion; (e) self-understanding, such as learning about yourself through feedback from other group members; (f) catharsis, or the reduction of emotional intensity through talk therapy; (g) instillation of hope, for example, the group members may experience more optimism largely due to witnessing change in others; (h) development of social skills, particularly those learned in the group setting; (i) vicarious learning and modeling, in that, other members learn from observing the therapeutic process within another group member that experiences similar symptoms; (j) interpersonal learning, such as group

members learning to respond to others more constructively; (k) imparting of information, which can often be thought of as the leader sharing information with the group members, such as psychoeducational information; (l) guidance, or group members advice-giving to each other; (m) existential issues, such as discussion of death, loneliness, and suffering; (n) corrective recapitulation of the primary family, such as understanding and working through previously established and systemic maladaptive patterns. In addition to the highly researched benefits of these process techniques within process-focused therapy, the emergence of these therapeutic factors may be further enhanced through the integration of psychoeducation.

Psychoeducation. Psychoeducational approaches are appropriate and beneficial for the acute inpatient psychotherapy group because they allow for interventions to be time-limited and efficient (Ettin & Vaughan, 1987; Poey, 1985). Psychoeducation has been defined as didactic information on illness and how to cope with it (Pitschel-Walz & Bäuml, 2009). Others have even defined psychoeducation simply as general learning (Ettin & Vaughan, 1987). Psychoeducational therapy groups often have content or a topic that is organized around a variety of symptoms or problems (Ettin & Vaughan, 1987; Poey, 1985). The content or topic of a psychoeducational therapy group offers a framework that can hold the group together while providing structure to the group's proceedings (Ettin & Vaughan, 1987). Although the traditional focus of the psychoeducational group is on content, the utilization of group processes has long been recognized to further psychoeducational therapy (Ettin & Vaughan, 1987; Pratt, 1921).

"Process characteristics are an intrinsic and inevitable aspect of all groups no matter what their size or function" (Ettin & Vaughan, 1987, p. 178; Whitaker &

Lieberman, 1964). Attention to group process is important in psychoeducation because it allows for relevant informational points to be selected (Ettin & Vaughan, 1987). "The sophisticated use of process can lubricate, support and move the content along to the next informational point" (Ettin & Vaughan, 1987, p. 178; Klein, 1985).

In addition, imparting of information and installation of hope are two therapeutic group process factors that can both emerge in group members when the group leader communicates educational points (Gonzalez & Prihoda, 2007; Yalom, 1995). The leader of the psychoeducational group needs to become skilled at balancing between the content or topic of the group and member reactions or processes (Ettin & Vaughan, 1987; Klein, 1985). The psychoeducational group considers both intellectual and emotional experiences (Cohn, 1969; Ettin & Vaughan, 1987).

The blending of process and content will create an educational experience that is engaging, personal and meaningful. Process should not be viewed as an interruption to learning but rather something that can facilitate the assimilation of information. In addition, group members have a need to discuss information that is imparted to them. This discussion will inevitably evoke various reactions from group members. Therefore, the utilization of process techniques must find a role in any psychoeducationl group (Ettin & Vaughan, 1987). The psychoeducational group leader can aim to support and personalize the content or topic through utilization of the group process. The leader can also respond to the feedback and emotional needs of group members by relating their process back to the group topic (Ettin & Vaughan, 1987; Shaffer & Galinsky, 1974).

A process-oriented psychoeducational method may be an appropriate treatment approach for the acute inpatient, diagnostically heterogeneous, brief duration

psychotherapy group. It appears that using aspects of process and psychoeducation allows for a flexible approach that is able to be used with a wide range of pathology including, psychosis, mood disorders and personality disorders. Therefore, a more in depth look at studies examining treatment approaches for these diagnoses is necessary in order to further understand the potential role and applicability of process and psychoeducation for the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group. Particular attention will be paid to the treatment approaches utilized, the composition, duration, and setting of the group.

Treatment approaches for psychosis. Fritz Perls (1951) emphasized the interaction between the whole and the elements of which the whole is composed; together forming a gestalt. "Elements of the Gestalt are organized according to laws of internal consistency; the meaning of the Gestalt appears only when the elements begin to integrate," (Serok & Zemet, 1983, pp. 417-418). Schizophrenia is a disturbance marked by disintegration and regression in conceptual perception and reality testing. This makes it difficult for the schizophrenic person to integrate information into a meaningful gestalt. There are two basic characteristics of schizophrenic conceptual perception; concretization of the concept and pathological thought processes. "Due to a lack of personal integration, the schizophrenic translates abstract emotions into more concrete forms which are comprehensible only to themselves," (Serok & Zemet, 1983, p. 418). Next, the schizophrenic's perception of reality is distorted, yet they act on these perceptions as if they were truths. Therefore, process-oriented group therapy may be a beneficial treatment approach because it offers the schizophrenic person the opportunity to obtain personal integration through interaction with the therapist and other group members.

A review of 40 studies showed that group therapy was superior when compared to a control group for schizophrenic patients on both the outpatient and the inpatient level (Kanas, 1984, 1985). Interaction oriented approaches tended to be more successful than insight oriented approaches (Kanas, 1985; Kanas et al., 1980; Pattison, Brissenden, & Whol, 1967). However, a homogeneous group in terms of diagnosis is preferred because specific techniques can be used and group cohesiveness may be better. Groups may want to focus on reality testing, encouraging contact or engagement with others, allowing the expression of emotions on a limited basis and education about practical matters. These techniques may help them gain awareness of how their actions affect their illness and relationships with others. Some have suggested that insight-oriented approaches should be avoided because the actively psychotic schizophrenic may be harmed by premature uncovering and self-disclosure (Kanas, 1985). Many studies have also looked at reality testing and engagement with others through the group process when it comes to treating schizophrenia.

A study by Serok and Zemet (1983) looked at Gestalt principles and methods with schizophrenic patients in group therapy at an inpatient psychiatric hospital. Participants were divided into an experimental and a control group. The experimental group met for a total of 10 weeks. Serok and Zemet suggested that Gestalt techniques would increase reality differentiation and perception. This study attempted to help patients differentiate perceptions and relate to concrete elements in reality, emphasize logical thinking and internalize reality perception. In order to help them differentiate between important and unimportant elements and relate to concrete elements, one technique may involve having the participant close their eyes and describe the seating order in the circle and clothing

worn by the participants. To emphasize logical thinking, participants were enabled to experience the basic organization of elements in order to help them reach more complete and clear communication. For example, participants may be requested to guess the mood of another or express that mood nonverbally. A discussion may then follow. This may also help with internalization of reality perception. Interestingly, Rorschach results from this study showed an increase in reality perception (Serok & Zemet, 1983).

Similar to research previously conducted by Serok and Zemet (1983) and Kanas (1985), a more recent study conducted by (Daniels, 1998) further explored the importance of interaction and the group process when treating schizophrenia. However, Daniels' approach focused on social skills training for schizophrenic patients by combining aspects of CBT and group process (IBT, 1998).

Interactive Behavioral Training (IBT) is a social skills training approach that focuses on cognitive behavioral techniques (i.e., instruction, modeling, behavioral rehearsal) and group process strategies. Cognitive behavioral therapy (CBT) approaches are commonly used to treat social impairment in the severely mentally ill (Carpenter, Heinrichs, & Alps, 1985; Daniels, 1998; Liberman, 1993). Learning how to recognize social cues, respond in a behaviorally appropriate manner and produce a variety of solutions to interpersonal problems can greatly improve one's social skills. However, the CBT approach alone often fails to translate outside of the treatment arena and interpersonal relationships often go unimproved (Daniels, 1998; Heinssen & Glass, 1990). It is argued that CBT alone lacks the interpersonal group process that is necessary for learning and interpersonal connections. Those with severe mental illness may experience more positive long-term effects through the emergence of group process

factors, such as altruism, group cohesiveness, self-disclosure and instillation of hope (Daniels, 1998).

Daniels (1998) also found interactive behavior training (IBT) to be effective with 40 outpatient group members who met criteria for schizophrenia or schizoaffective disorder. After 16 sessions, IBT led to an increase in overall social competence, a reduction in negative symptoms and allowed for the emergence of therapeutic group process factors for schizophrenic patients. Although this study was conducted at the outpatient level, aspects of IBT (i.e., instruction, modeling and interpersonal connections) may be found useful during group psychotherapy for inpatients suffering from schizophrenia.

Although the previous study conducted by Daniels (1998) included patients suffering from schizoaffective disorder, the literature tends to be limited when it comes to psychological treatments for depressive disorders with psychosis. Co-morbidity between depression and psychosis can be common for those suffering from schizophrenic disorders (Bartels & Drake, 1988; Hagan et al., 2005). This co-morbidity creates an increase in overall symptom severity, complexity, impairment in functioning, poor treatment response, and risk of psychotic relapse (Hagan et al., 2005; Hausmann & Fleischhacker, 2002). Hagan et al. (2005) conducted a study that included 17 participants who were diagnosed with schizophrenia or schizoaffective disorder with co-morbid depression, from inpatient and outpatient psychiatric hospital clinics. Participants went through eight weeks of outpatient manualized cognitive behavioral group therapy (CBGT). The treatment was delivered as a mix consisting of psychoeducation and cognitive therapy related to depression and psychosis, in addition to role-plays, group

exercises and homework assignments. Results showed that this model was effective in treating depressive symptoms and psychosocial functioning. However, it was less effective in changing self-esteem, maladaptive schemas or psychotic symptoms (Hagan et al., 2005).

When it comes to treating schizophrenic or psychotic spectrum patients via group psychotherapy, fostering interpersonal connections within the group appears to be a key aspect. For instance, Kanas' (1985) review of 40 studies revealed that groups focusing on reality testing and engagement with others can help schizophrenic patients gain awareness of how their actions affect their illness and relationships with others. Serok and Zemet (1983) found that Gestalt techniques focused on interpersonal connections within the group increased reality perception. Daniels (1998), found that IBT (i.e., instruction, modeling and interpersonal connections), led to an increase in overall social competence, a reduction in negative symptoms and allowed for the emergence of therapeutic group process factors for schizophrenic patients. In addition, there is some evidence for the use of psychoeducation when treating schizophrenic patients. Hagan et al. (2005) found that an approach consisting of psychoeducation and cognitive therapy related to depression and psychosis was effective in treating depressive symptoms and psychosocial functioning. These studies appear to have utilized both aspects of process and psychoeducation within their treatment approach. However, the aforementioned studies all pertain to a diagnostically homogenous psychotherapy group, in which all participants within these groups were diagnosed with psychotic spectrum disorders. In addition, treatment duration tended to last for several sessions or weeks, and groups were located at a mixture of inpatient and outpatient settings.

Treatment approaches for mood disorders. Bipolar disorder is characterized by the recurrence of manic and depressive episodes which are common and debilitating (Gonzalez & Prihoda, 2007). Less than 50% of patients diagnosed with bipolar disorder are able to achieve stable remission (Goldberg, Harrow, & Grossman, 1995; Vukov, Moore, & Cupina, 2007). Studies have shown that those suffering from bipolar disorder struggle with cognitive impairment (i.e., poor attention and executive functioning) that leads to interpersonal, employment and treatment difficulties (Martinez-Aran, Vieta, Colom et al., 2004; Vukov, Moore, & Cupina, 2007). Research has also shown that psychoeducation can help those suffering with bipolar disorder in the areas of self-confidence, and social functioning (Van Gent, Vogtlander, & Vrendendaal, 1998; Vukov, Moore, & Cupina, 2007). In addition, group therapy that focuses on the process of feedback, interpersonal skills and self-awareness may contribute to the improvement of social functioning, flexibility in thinking and improved problem solving (Vukov, Moore, & Cupina, 2007). Patients in group therapy have also found that addressing existential concerns (i.e., death, freedom, meaninglessness) is helpful in their recovery (Yalom, 1980). This may be important to consider when treating the bipolar patient because they may be experiencing great existential conflicts (Vukov, Moore, & Cupina, 2007).

Vukov, Moore, and Cupina (2007) also examined a group therapy technique with 10 patients diagnosed with bipolar disorder which focused on psychoeducation, cognition and existential issues. Group therapy was conducted at the outpatient level and lasted for nearly two years. Psychoeducation techniques were aimed at providing information about bipolar disorder and illness management. Cognitive interventions through group feedback and observations focused on rigid thinking, set shifting, planning, organizing and

judgment. Existential concerns were addressed in the later stages of the group, some examples included: personal limits, mortality and meaning in light of decisions around children and careers. Results showed improvement in social functioning (i.e., family, employment), satisfaction with the group process and no re-hospitalizations were needed.

In a recent study by Gonzalez and Prihoda (2007), the effectiveness of a psychodynamic approach with group process techniques and psychoeducation all woven into an illness management approach for eleven patients with bipolar disorder was examined. The group duration was long-term (16 months) and took place at the outpatient level. The treatment approach used was an adaptation of the IOM (Integrative Outpatient Model) for bipolar disorder (Gonzalez & Prihoda, 2007; Kanas, 1993). The IOM consisted of three goals for group sessions. The first goal was to offer psychoeducation about bipolar disorder. The second goal was to discuss illness management themes or issues in bipolar disorder. The third goal was to explore the quality of relationships through group process techniques which included general discussion, feedback, and discussion of interpersonal issues. Results suggested that patients experienced benefits for depressive but not manic symptoms (Gonzalez & Prihoda, 2007).

The previous studies on bipolar disorder appear to emphasize an approach that utilized aspects of both psychoeducation and process. Vukov, Moore, and Cupina (2007) used an approach that focused on psychoeducation about bipolar disorder and illness management and cognitive interventions through group feedback. Gonzalez and Prihoda (2007) also used a very similar approach. Results from these studies showed improvement in social functioning, satisfaction with the group process, no re-hospitalizations, and beneficial effects for depressive symptoms (Gonzalez & Prihoda,

2007; Vukov, Moore, & Cupina, 2007). However, these studies were conducted on homogeneous groups with respect to diagnosis, as all group participants were diagnosed with bipolar disorder. In addition, groups were long-term in duration lasting anywhere from 16 months to 2 years.

Clinical depression is a significant public health concern and is perhaps the most common problem encountered in clinical practice (Dobson & Ottenbreit, 2004; Eaton et al., 1989). Rates of depression are increasing; the World Health organization predicted that by the year 2020, depression is the disorder that will have the highest total burden of care worldwide (Dobson & Ottenbreit, 2004; Murray & Lopez, 1997). Depression is becoming more recognized as a recurrent disorder, as 40-60% of individuals who recover from a major depressive episode will have another such episode at some point later in their lives (Belsher & Costello, 1998; Dobson & Ottenbreit, 2004; Keller et al., 1986).

A meta-analysis of controlled outcome studies revealed that group therapy can be equally as effective as individual therapy for treating depression (Neimeyer, et al., 1995; Neimeyer et al., 1989). A collaborative study of depression showed that cognitive, interpersonal and pharmacological approaches were equivalent in treating clinical depression (Elkin et al., 1989; Neimeyer et al., 1995; Sotsky et al., 1991). Although extensive research has been conducted in the previous twenty years, there is still controversy around what combinations of treatment make for the most effective approach for treating clinical depression (Neimeyer et al., 1995).

In spite of this controversy, diagnosis specific cognitive behavioral therapies (CBT) for anxiety and depression have shown to be effective (Butler, Chapman, Forman, & Beck, 2006; McEvoy & Nathan, 2007). Interestingly, the similarities between these

disorders may outweigh the differences because co-morbidity is common. Therefore, effective treatments may not have to be disorder specific (Barlow, Allen, & Choate, 2004; McEvoy & Nathan, 2007).

McEvoy and Nathan (2007) conducted a study to evaluate the effectiveness for mixed diagnosis CBT psychotherapy groups for depression and anxiety. Group treatment lasted 10 weeks at an outpatient setting. Inpatients and others meeting criteria for schizophrenia, eating disorders or substance abuse were excluded. Treatment was based on Beck's (1979) depression manual and Barlow and Craske's (1994) anxiety manual. Treatment was composed of the following: psychoeducation about depression and anxiety, calming techniques, behavioral activation tasks, exposure tasks, cognitive restructuring while utilizing aspects of group process. Results showed that symptoms of anxiety and depression significantly improved (McEvoy & Nathan, 2007). However, this study was conducted at the outpatient setting which leaves questions about treating depression with an inpatient population.

Neimeyer et al. (1995) studied 352 inpatients admitted to a mood disorders program in a short-term private psychiatric hospital located in Tennessee. All of the patients involved in this study met criteria for major depressive disorder. This program provided individual, pharmacological, educational, milieu and group therapy all as a treatment approach. Group therapy sessions were highly structured containing a sequence of topics that focused on self help skills. Results showed improvement across cognitive and vegetative factor scores from the Beck Depression Inventory. Generalizability from this study may be limited because it was a naturalistic study (i.e., uncontrolled design).

However, the aspects of psychoeducation that were used in this study may be applicable to the depressed inpatient within the diagnostically heterogeneous psychotherapy group.

The previously mentioned studies both used aspects of psychoeducation and process techniques when treating depression and anxiety. McEvoy and Nathan (2007), examined an approach using: psychoeducation about depression and anxiety, calming techniques, behavioral activation tasks, exposure tasks and cognitive restructuring. While Neimeyer et al. (1995) also looked at education in addition to topics related to self help skills within the context of group therapy. Results from both studies showed that symptoms of anxiety (McEvoy & Nathan, 2007) and or depression (McEvoy & Nathan, 2007; Neimeyer et al., 1995) improved. However, treatment was either conducted at the outpatient level, lasted several weeks and or consisted of relatively homogeneous groups composed of participants diagnosed with depression and or anxiety.

Treatment approaches for personality disorders. Some have argued that the high prevalence and heavy service utilization of personality disorders make them the most costly of all psychiatric conditions. Personality disorders have developmental causal pathways, where significant life events have influenced the development of one's personality (Winship & Hardy, 2007). However, personality disorders are often viewed as a problem of choice and self control and not a real illness because it is generally accepted that there are no major biological causal pathways (Kendall, 2002; Winship & Hardy, 2007). This notion combined with a disinterest by pharmaceutical companies may both be contributing to the lack of scientific papers examining personality disorders (Winship & Hardy, 2007).

As previously mentioned, the majority of inpatients diagnosed with a personality disorder are of the borderline type, which may be related to a greater frequency of self-injurious acts (Clarkin et al., 1983; Cowdry et al., 1985; Simon, 1994; Widiger & Frances, 1989). One study showed that suicide rates for these patients ranged from 7% to 36% depending on the number of DSM criteria met (Simon, 1994; Stone, 1989). Some inpatient groups exclude disruptive borderline personalities from group therapy; however, due to their suicide rates and prevalence in the inpatient setting, it is imperative that they receive group treatment (Freeman et al., 1993; Simon, 1994). Up to 72% of borderline personality disorder patients have inpatient stays where group therapy is the common treatment modality (Farrell et al., 2008).

Due to the evidence for developmental causal pathways, common treatment approaches for personality disorders include dynamic therapy which explores life events that may have contributed to a damaged personality (Winship & Hardy, 2007). Efficacy for a psychodynamic treatment approach has been found for patients with cluster A, B and C personality disorders. A psychodynamically oriented inpatient treatment program that included individual and group therapy was found to reduce symptoms of personality pathology and improve social functioning for patients with cluster A, B and C personality disorders. The duration of this treatment program was 3-6 months (Stichting Klinische Psychotherapie, 2001; Verheul & Herbrink, 2007). A different inpatient program, more specific to borderline personality disorder, was studied for the duration of three months. BASE (Borderline Personality Disorder Acquire Skills and Empowerment) is a cognitive affective approach group therapy approach. In this approach, group processes attempt to address patterns of avoidance, isolation, conflict, lack of belonging, unworthiness and

rejection sensitivity that people with borderline personality disorder experience. The four components of this approach are psychoeducation, emotional awareness, distress management and schema change. Schemas include one's beliefs about themselves, the world and others which are rooted in childhood. An important aspect of altering maladaptive schemas is to identify maladaptive coping mechanisms and employ healthier coping styles. Results from this study showed a reduction in borderline personality disorder symptoms, suicide attempts and hospitalizations (Farrell et al., 2008).

The aforementioned studies examined psychodynamic and cognitive affective treatment approaches for inpatients diagnosed with borderline personality disorder. Dynamic therapy explores life events that may have contributed to a damaged personality (Winship & Hardy, 2007). A psychodynamically oriented inpatient program found group therapy to reduce symptoms of cluster B personality pathology (Stichting Klinische Psychotherapie, 2001; Verheul & Herbrink, 2007). A cognitive affective oriented inpatient program used group processes to focus on psychoeducation, emotional awareness, distress management and schema change. Results also showed a reduction in borderline personality disorder symptoms (Farrell et al., 2008). However, these studies were long term in duration and or homogeneous with respect to group composition.

Approaches for heterogeneous groups. Cognitive Behavioral Therapy (CBT) has been used effectively in outpatient therapy for several years (Turkington, Kingdom, & Weiden, 2006; Veltro et al., 2008). However, the use of CBT in acute inpatient settings has rarely been reported (Veltro et al., 2008; Wykes & Landau, 1999). Treatment tends to be crisis oriented, stabilizing and focused on controlling positive symptoms (Veltro at al., 2008). Manualized CBGT places more of an emphasis (in

comparison to CBT) on the vulnerability stress model and patients coping abilities (Falloon & Fadden, 1993; Veltro et al., 2008). Its goals are to improve treatment adherence, reduce violent acts, and improve collaboration between patients and between patients and professionals. Other goals of this approach are to assist patients in coping with mental illness, normalize their experience, reduce isolation by sharing their experience and increase self-esteem. This model includes structured sessions, rules and group strategies (Veltro et al., 2008; Vendittelli, Veltro, & Oricchio et al., 2003).

A study by Veltro et al. (2008) looked at readmissions, patient satisfaction, ward atmosphere, use of restraints and length of hospital stay for a five year period in an inpatient psychiatric hospital. The first year was without the CBGT approach and the following four years was with it. The diagnoses that were studied included schizophrenia, depression, bipolar and personality disorders (primarily borderline). Results showed a reduction in readmission rates, improved patient satisfaction, ward atmosphere and reduction in violent episodes. However, results were least effective for depression. Although this study reported an approach that has success with a variety of diagnoses, the composition of the therapy groups was not made explicitly clear. It is unknown whether or not patients were separated according to diagnoses or whether groups were mixed. In addition, the study was long-term in duration.

Simon (1994) implemented the cognitive therapy (CT) program at an inpatient psychiatric hospital in southern California. The program consisted of 15 one hour therapy groups each week. The goals were to reduce hopelessness, teach CT skills tailored to specific problem areas, identify schemas and implement a plan for change. The groups were heterogeneous and consisted of diagnoses such as; major depressive episode, PTSD,

bipolar disorder and borderline personality disorder, most commonly. However, active psychosis, mania, and those under heavy sedation were excluded and participated in alternative programs. Newcomers were socialized to the group by introducing themselves and explaining why they have been admitted. Next, newcomers watched continuing participants report on homework assignments from the previous day or bring up a problem to be addressed in a CBT manner. New patients then remained for a brief discussion where they are given a description of the cognitive model, an explanation of how the model applies to them and they are given a workbook with instructions. In sum, groups were heterogeneous, open-ended, educational and process oriented for the severely disturbed, non-psychotic patient. However, the empirical effectiveness of this study was unknown because outcome results measuring depression and cognitive skills learned were not yet analyzed at the time of this study (Simon, 1994).

Brabender and Fallon (1993) authored a book on inpatient group psychotherapy and offered several variables to consider when choosing or implementing a treatment model. First, it is important to consider the duration of the group. The composition of the psychiatric inpatient therapy group is highly unstable due to rapid client turnover (Yalom, 2005). If group membership changes on a daily basis then a cross sectional approach may best. This approach regards a single session as the entire life of the group where learning is not dependent upon participation in prior sessions (Brabender & Fallon, 1993). Yalom (2005) agrees with this notion, "the inpatient group therapist must adopt a radically shortened time frame and consider the life of the group to be only a single session" (p. 488).

The current psychiatric inpatient unit consists of patients with a wide range of pathology, including psychosis, borderline and major affective disorders (Yalom, 2005). Treatment approaches for a diagnostically heterogeneous group should theoretically be able to practically accommodate a range of diagnoses, symptoms and ego functioning. Diagnosis may be predictive of ego functioning and the resources that a patient brings to group. Therefore a diagnostically heterogeneous group may indicate a group that consists of a range of ego functioning. Heterogeneity in terms of ego functioning means that approaches should be designed for the lower level of functioning that includes individually directed interventions tailored to the resources of the higher functioning patient. Lower functioning patients may need a more supportive approach so they can learn to be trusting of others (Brabender & Fallon, 1993). Yalom (2005) also advocates for inpatient group therapists to adopt a more supportive and less confrontational approach. A more supportive approach will allow patients to feel understood and begin to buy into the treatment process and further engage in therapy upon discharge. However, others suggest some confrontation for higher functioning patients because they may need to experience a little anxiety in order to learn about their dysfunctional interpersonal patterns (Brabender & Fallon, 1993; Leopold, 1977).

Gender and age are two additional variables that are also important to consider when conducting an inpatient group. Mixed gender groups call for a cognitive affective approach because an overly cognitive approach can disenchant the women and an overly affective approach can disenchant the men. When a group is heterogeneous with respect to age the therapist needs to spend some time getting to know the characteristics of the population in order to tailor the approach. The heterogeneous group allows the therapist

to be more flexible in regards to their approach (Brabender & Fallon, 1993). It is also important that the inpatient has achievable goals. Yalom (2005) listed six such goals; engaging the patient in the therapeutic process, demonstrating that talking helps, problem spotting, decreasing isolation, being helpful to others and alleviating hospital related anxiety.

Therefore, Brabender and Fallon (1993) and Yalom (2005) both offer helpful variables to consider when conducting a diagnostically heterogeneous, rapid turnover inpatient psychotherapy group. Rapid turnover calls for a cross sectional approach that regards a single session as the entire life of the group where learning is not dependent upon participation in prior sessions (Brabender & Fallon, 1993; Yalom, 2005). Treatment approaches should theoretically be able to practically accommodate a range of diagnoses, symptoms and ego functioning. The therapist needs to spend more time getting to know patients in order to tailor the approach (Brabender & Fallon, 1993). Lower functioning patients may need more support and higher functioning patients may need more confrontation (Brabender & Fallon, 1993; Yalom, 2005). In addition, women need more of an affective approach and men need a more cognitive approach (Brabender & Fallon, 1993). Lastly it is important for the group to have achievable goals (Yalom, 2005). An approach that seems most effective in achieving realistic treatment goals in a time-limited manner for a heterogeneous inpatient group should be flexible in regard to both content and process. A treatment approach that consists of both aspects of process and psychoeducation appears to best suited for this type of group. Therefore in order to provide a proposed treatment model, it is important to focus more on the common factors

of process and psychoeducational found within group therapy studies examining effective approaches for psychosis, mood disorders and personality disorders.

Common Factors of Process

Process and psychosis. Recent research in the treatment of schizophrenia has demonstrated that the facilitation of group process is essential in enhancing group interactions and group member engagement, both with each other and with the group leader. For example, Daniels (1998; see also Yalom, 2005) recommends the facilitation of group therapy process through implementing group process factors such as altruism, group cohesion, self-disclosure, and the instillation of hope. It addition, it has been recommended that these group process factors be implemented in the 'here-and-now', as well as inclusive of group leader's personal reaction and judicial self-disclosure (Brabender & Fallon, 1993). It was also found that increasing patient awareness through the emergence of group process factors led to long-term positive effects that improved overall social functioning. In addition, it was found that these group process strategies allowed for increased motivation for learning and interpersonal relationships (Daniels, 1998; Yalom 2005). Additionally, it was found that process-oriented, reality-based, supportive approaches with groups comprised primarily of patients with schizophrenia were beneficial (Kanas, 1988).

Process and mood disorders. Other research in the treatment of bipolar disorder has demonstrated that group process-oriented therapy can lead to flexibility of thought, better psychosocial function, and improvement in problem-solving skills. It is also recommended for borderline and bipolar disorders, the group leader implement specific process factors in order to reach these goals, such as emphasizing feedback, interpersonal

skill development, and increasing self-awareness. Additionally, the authors emphasize Yalom's therapeutic group factors, such as instillation and maintenance of hope, developing social skills, consequential thinking, reality testing, learning responsibility, experiencing universality, altruism, and group cohesiveness, and also learning interpersonal skills and how to appropriately discuss and address existential conflicts (Vukov, Moore, & Cupina, 2007; Yalom, 1998).

A study by Slife et al. (1989) examined processing ability in patients with major depression. Patients viewed simulations of group therapy interactions and were then rated on comments that reflected process quality and accuracy. Results suggested that depressed patients were less capable of processing interactions. Therefore, the study questioned the use process techniques with severely depressed patients. Although the researchers attempted to measure the realism of the simulations for the subjects, actually engaging in process-oriented group therapy geared toward the treatment of depression may facilitate processing ability. For instance, research has also demonstrated the benefit of implementing Yalom's (2001) critical factors in psychotherapy, specifically providing corrective emotional experiences in process-oriented group psychotherapy for the treatment of severe depression. Specifically, these authors directed their process-focus towards re-stating the situation that may have led to the depressive feelings, discussion of the situation within the group context, encouragement of healthier coping mechanisms and interactional patterns, and social reinforcement or advice-giving from the group as a new coping response (Whitaker & Deikman, 1980).

Process and personality disorders. Cloitre and Koenen (2001) found that specifically when working with borderline personality disorder, if there are two therapists

co-leading the process-oriented group together, and the focus is on here-and-now processing of the group member relationships, group members were better able to work through relationship dynamics that may cause them struggles. It was also found that a smaller group size, and illuminating interpersonal themes was important to moving the process forward with borderline personal disorder. It has also been found that self-understanding and altruism are the most effective components of process-oriented group psychotherapy with borderline personality disorder. The empathic connection with the therapist was described by the participants in the study as soothing and comforting previously instilled emotional ailments, which are often responsible for borderline emotionally labile characteristics. The group dynamic further soothes and comforts those ailments by offering containment for their anger and despair, at the same time modeling how to interact in a health group interpersonal process without exacerbating their current emotional states (Higgitt & Fonagy, 1992).

Process and heterogeneous groups. Research has also found that if the group is primarily comprised of regressed or lower functioning individuals with heterogeneous diagnoses, emotionally supportive process-focused therapy has been found to be the most beneficial (Brabender & Fallon, 1993). In addition, research has demonstrated that process-oriented interpersonal groups benefit from two aims for treatment: (a) providing a safe and supportive group therapy environment with further allows for interpersonal exploration and an increase in connection and group cohesion, and (b) broadening the group members' awareness of self and other, and also the interaction between self and others (Johnson, 2009).

Therefore, a process-oriented treatment approach for the diagnostically heterogeneous psychotherapy group should focus on facilitating group process in order to enhance group interactions and group member engagement, both with each other and with the group leader (Daniels, 1998). The facilitation of group therapy process should occur through implementing Yalom's (2005) therapeutic group factors (Daniels, 1998; (Vukov, Moore & Cupina, 2007; Yalom, 1998). These group process factors can be implemented in the 'here-and-now' by including the group leader's personal reaction and judicial self-disclosure (Brabender & Fallon, 1993), and by offering an explanation for 'here-and-now' interpersonal relationships (Slife et al., 1989; Yalom, 1983). Implementing these process factors can also be done by emphasizing feedback and altruism, interpersonal skill development, and increasing self-awareness and self-understanding (Higgitt & Fonagy, 1992; Vukov, Moore & Cupina, 2007; Yalom, 1998). In addition, it is important for group members to experience a supportive, empathic connection with the group leader (Brabender & Fallon, 1993; Higgitt & Fonagy, 1992). Others can benefit from restating the situation that may have led to their hospitalization, discussion of the situation within the group context, encouragement of healthier coping mechanisms and interactional patterns, and social reinforcement or advice-giving from the group as a new coping response (Whitaker & Deikman, 1980).

Common Factors of Psychoeducation

Psychoeducation and psychosis. Controlled outcome studies have indicated that psychoeducation for patients diagnosed with schizophrenia have shown to be beneficial. After receiving psychoeducation, patients diagnosed with schizophrenia have shown improvement in treatment compliance, social functioning, insight into illness and

participation in aftercare. In addition, lower relapse rates, and decreased negative symptoms and rehospitalization rates have also been reported (Ascher-Svanum & Whitesel, 1999; Pitschel-Walz & Bäuml, 2009). Some of the psychoeducation topics that have been studied in the treatment of schizophrenic disorders include: diagnosis, stress, community resources, substance use, support systems, warning signs and relapse prevention (Ascher-Svanum & Whitesel, 1999).

A recent study by in Germany by Bechdolf et al. (2010) compared the effectiveness of 8-week CBT and psychoeducation treatment groups on quality of life for schizophrenic inpatients. The CBT approach utilized aspects of coping skills, enhancing problem-solving abilities, relapse prevention and sharing information (i.e., about voices and delusions). Some of the topics used in the psychoeducation approach included symptoms of psychosis, warning signs of relapse, relapse prevention and information about medication. Results indicated that patients experienced an increase in quality of life for both CBT and psychoeducation groups. However, there was not a significant difference between the two treatment approaches (Bechdolf et al., 2010).

Hagan et al. (2005) conducted a study that included 17 participants who were diagnosed with schizophrenia or schizoaffective disorder with co-morbid depression, from inpatient and outpatient psychiatric hospital clinics. Participants went through eight weeks of outpatient manualized cognitive behavioral group therapy (CBGT). The treatment was delivered as a mix consisting of psychoeducation and cognitive therapy related to depression and psychosis, in addition to role-plays, group exercises and homework assignments. Results showed that this model was effective in treating depressive symptoms and psychosocial functioning (GAF). There was also a significant

effect on treating depression in schizophrenic disorders with no incidents of relapse at both post-treatment and at six months follow-up. However, results also found that CBGT was less effective in changing hopelessness, self-esteem, maladaptive schemas or psychotic symptoms (Hagan et al., 2005).

Although this treatment approach consisted of manualized CBGT techniques over the course of eight weeks, there were aspects of psychoeducation used that may be applicable to the acute, brief duration, heterogeneous inpatient group, especially for patients with diagnoses relating to psychosis and depression and perhaps even maladaptive personality patterns. The psychoeducation aspects of treatment geared towards psychosis included: information about psychotic symptoms, understanding the warning signs that lead up to a psychotic relapse, and coping with psychotic symptoms. The psychoeducational aspects of treatment geared towards depression included: information about symptoms of depression, and identifying triggers for depression. They also discussed the importance of friends, social networks and leisure time as coping mechanisms for both psychotic and depressive symptoms. In addition time was spent discussing the relationship between self-esteem, self assertiveness and depression. Finally relapse prevention was also discussed (Hagan et al., 2005).

Psychoeducation and mood disorders. In a recent study by Gonzalez and Prihoda (2007), the effectiveness of a psychodynamic approach with group process techniques and psychoeducation all woven into an illness management approach for eleven patients with bipolar disorder was examined. The group duration was long-term (16 months) and took place at the outpatient level. The treatment approach used was an adaptation of the IOM (Integrative Outpatient Model) for bipolar disorder (Gonzalez &

Prihoda, 2007; Kanas, 1993). The IOM consisted of three goals for group sessions. The first goal was to offer psychoeducation about bipolar disorder. The second goal was to discuss illness management themes or issues in bipolar disorder. The third goal was to explore the quality of relationships through group process techniques which included general discussion, feedback, and discussion of interpersonal issues. The approach was flexible and allowed for a balance between psychoeducation and group process. Results suggested that patients experienced benefits for depressive but not manic symptoms (Gonzalez & Prihoda, 2007). Symptoms of mania may not have improved because patients included in the study had a recent bipolar mood episode. However, the authors concluded that the treatment of mania may be benefited by spending more time on psychoeducation about the need to adhere to antimanic agents or medication.

The content of psychoeducation topics was based on group member interests which included several illness management themes (i.e., medication, diagnoses, crisis', and social support). This study took place on the outpatient level, was long-term and utilized aspects of psychodynamic treatment which has been considered by some to be too lengthy of an approach (Gonzalez & Prihoda, 2007). However, the aspects of process and psychoeducation that were implemented may be directly applicable to inpatients struggling with depressive and manic symptoms in an acute heterogeneous psychotherapy group. In particular the flexible balance between psychoeducation and process techniques may be most useful. Psychoeducation about illness management themes (i.e., medication, diagnoses, crisis', and social support) and group process techniques consisting of general discussion and feedback appear to be most relevant.

Research has shown that psychoeducation can help those suffering with bipolar disorder in the areas of self-confidence and social functioning (Van Gent, Vogtlander, & Vrendendaal, 1998; Vukov, Moore, & Cupina, 2007). In addition, psychoeducation can increase self-management abilities which in turn reduces relapses and hospital admissions (Colom, Vieta, Goikolea, et al., 2002; Colom, Vieta, Martinez-Aran, et al., 2003; Colom, Vieta, Reinares, et al., 2003; Vukov, Moore, & Cupina, 2007). Interestingly, group therapy that focuses on the process of feedback, interpersonal skills and self awareness may contribute to the improvement of social functioning, flexibility in thinking and improved problem solving (Vukov, Moore, & Cupina, 2007). Patients in group therapy have found that addressing existential concerns (i.e., death, freedom, meaninglessness) to be helpful in their recovery (Yalom, 1980). This may be important to consider when treating the bipolar patient because they may be experiencing great existential conflicts (Vukov, Moore, & Cupina, 2007).

A study by Vukov, Moore, and Cupina (2007) examined a group therapy technique with 10 patients diagnosed with bipolar disorder which focused on psychoeducation, cognition and existential issues. Group therapy was conducted at the outpatient level and lasted for nearly two years. Psychoeducation techniques were aimed at providing information about bipolar disorder and illness management. The goals of psychoeducation were to improve symptom recognition, adherence to treatment and psychosocial functioning. Cognitive interventions through group feedback and observations focused on rigid thinking, set shifting, planning, organizing and judgment. Existential concerns were addressed in the later stages of the group, some examples included: personal limits, mortality and meaning in light of decisions around children and

careers. Results showed improvement in social functioning (i.e., family, employment), satisfaction with the group process and no re-hospitalizations were needed (Vukov, Moore, & Cupina, 2007).

Although this study was long-term, conducted at the outpatient level and consisted of some cognitive techniques, aspects of process and psychoeducation that were used may be applicable to inpatients with bipolar disorder in acute heterogeneous psychotherapy groups. Some of the psychoeducation topics that were used included: information about bipolar disorder, symptom recognition, stress management and aspects of relapse prevention (Vukov, Moore, & Cupina, 2007). In addition, group processing that focused on consequential thinking and validation were used. These process techniques allowed group members to discuss the positive and negative outcomes of actions while also providing challenges and validation of their judgment, insight and perceptions of reality (Vukov, Moore, & Cupina, 2007). Process techniques also focused on existential issues that emerged during the depressive stage when patients reflected on the consequences of their behavior in the manic stage. These topics focused on morality, meaning, personal limits, responsibility and misunderstanding freedom (Vukov, Moore, & Cupina, 2007).

There is evidence that relapse rates in depression are high. This has created an emphasis on having a more complete understanding of the relapse process in depression including methods to decrease the risk of relapse (Dobson & Ottenbreit, 2004). McEvoy and Nathan (2007) conducted a study to evaluate the effectiveness for mixed diagnosis CBT psychotherapy groups for depression and anxiety. Group treatment lasted 10 weeks at an outpatient setting. Treatment was based on Beck's (1979) depression manual and

Barlow and Craske's (1994) anxiety manual. Treatment was composed of the following: psychoeducation about depression and anxiety, and CBT techniques which included: behavioral activation tasks, exposure tasks and cognitive restructuring. Results showed that symptoms of anxiety and depression significantly improved (McEvoy & Nathan, 2007). However, this study was conducted at the outpatient setting and lasted a period of ten weeks which leaves questions about treating depression and anxiety at the acute inpatient level. In addition, CBT was a large part of the treatment approach. Yet, there may be relevant aspects of this treatment approach for inpatients suffering from depression and anxiety in acute heterogeneous groups, in particular, the psychoeducation of depression and anxiety.

Neimeyer et al. (1995) studied 352 inpatients admitted to a mood disorders program in a short-term private psychiatric hospital located in Tennessee. All of the patients involved in this study met criteria for major depressive disorder. This program provided individual, pharmacological, educational, milieu and group therapy all as a treatment approach. Group therapy sessions were highly structured containing a sequence of topics that focused on self help skills. Results showed improvement across cognitive and vegetative factor scores from the Beck Depression Inventory. Patients were discharged after a few weeks. Although this study was conducted on inpatients suffering from depression, groups were homogeneous with respect to diagnosis, patients were admitted for a few weeks and the treatment approach was largely based upon CBT. However, aspects of this treatment approach that may be directly applicable to acute inpatients suffering from depression in heterogeneous group therapy. For instance the use of education as it relates to self help or coping skills.

A study by Moffat et al. (1995) utilized a psychoeducational approach for geriatric inpatients suffering from symptoms of both depression and anxiety. One aspect of the psychoeducational focus was to help group members identify and label emotions. Groups also focused on learning how to have fun again. This helped patients become more aware of the relationship between engaging in enjoyable activities and mood. Although this study did not provide empirical results, it did offer techniques for treating inpatients suffering from depression with or without accompanying anxiety. In addition, this approach was utilized with geriatric inpatients. However, these psychoeducational methods offered may be relevant for adult inpatients as well, such as by raising awareness about the relationship between mood and behavior, and thereby enhancing healthier coping styles.

Psychoeducation and personality disorders. Although there appears to be very little research regarding the use of psychoeducation and personality disorders, namely the borderline type, the aforementioned study by Hagan et al. (2005) may shed some light in this area. This study utilized aspects of psychoeducation that focused on understanding symptoms, recognizing triggering stressful events and developing new coping mechanisms. Results showed a significant decrease in Negativistic personality patterns. MCMI-III results also indicated that Borderline personality patterns decreased at both post-treatment and at six months, however, these results were not significant.

Psychoeducation and heterogeneous groups. A study by Veltro et al. (2008) looked at readmissions, patient satisfaction, ward atmosphere, use of restraints, and length of hospital stay for a 5-year period in an inpatient psychiatric hospital. The first year was without the CBGT approach and the following four years was with it. The

diagnoses that were studied included schizophrenia, depression, bipolar and personality disorders (primarily borderline). Results showed a reduction in readmission rates, improved patient satisfaction, ward atmosphere and reduction in violent episodes. However, results were least effective for depression. (Veltro et al., 2008). Although this study reported an approach that has success with a variety of diagnoses, the composition of the therapy groups was not made explicitly clear. It is unknown whether or not patients were separated according to diagnoses or whether groups were mixed. In addition, the study was long-term in duration. This study used a CBGT treatment approach which employed a psychoeducational component aimed at reducing factors associated with hospital admissions such as stress and coping. The authors argue that a flexible, psychoeducational approach can be effective for acute inpatients who are hospitalized for even a few days (Veltro et al., 2008).

Interestingly, another recent study conducted in Turkey examined a psychoeducation approach for inpatients diagnosed with schizophrenia, bipolar disorder, and recurrent depression. The treatment duration lasted 2 weeks and consisted of six psychotherapy groups. The psychoeducational topics from these six sessions included: understanding schizophrenia and its symptoms, the importance of medication, side effects of medication, coping with side effects, recognizing warning signs of relapse, and developing plans or coping skills to prevent relapse. The results of this study showed that psychoeducation for inpatient groups appeared to foster knowledge about mental illnesses, treatment, and enhance discharge readiness (Duman et al., 2010). Although the composition of therapy groups, with respect to diagnosis, was not made explicitly clear,

results from this study suggest that psychoeducational approaches can be effective for a wide range of diagnoses.

Psychoeducation Topics

The aforementioned studies provide insight regarding the aspects of psychoeducation that may be applicable to the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group. The psychoeducation aspects or topics that appear to be relevant to a wide range of diagnoses include: identifying symptoms, gaining awareness of triggers (e.g., stressful events) that lead up to symptom onset and exacerbation, and coping with triggers and symptoms (Duman, 2010; Gonzalez & Prihoda, 2007; Hagan et al., 2005; Vukov, Moore, & Cupina, 2007).

Identifying diagnoses/symptoms. Psychoeducation regarding diagnosis or symptom identification is one of the psychoeducational factors or topics utilized in treating schizophrenia. For instance, this technique has demonstrated improvement in treatment compliance, social functioning, insight into illness, participation in aftercare, lower relapse rates, decreased negative symptoms and lower rehospitalization rates (Ascher-Svanum & Whitesel, 1999). Other studies emphasizing the understanding of psychotic symptoms within their treatment approach have indicated that patients experienced an increase in quality of life (Bechdolf et al., 2010). Another study investigating CBGT for schizoaffective patients was successful in treating depressive symptoms and increasing psychosocial functioning. Aspects of psychoeducation used in this approach included identifying psychotic and depressive symptoms, identifying triggers and coping (Hagan et al., 2005).

In addition, psychoeducation regarding diagnosis or symptom identification is one of the psychoeducational topics utilized in treating bipolar disorder. For instance, Gonzalez and Prihoda (2007) studied an adapted version of the IOM (Integrative Outpatient Model) for bipolar disorder. Two factors utilized in this approach included psychoeducation about bipolar disorder and illness management (i.e., diagnosis and social support). Results indicated benefits for depressive symptoms. A study by Vukov, Moore, and Cupina (2007) examined a group therapy technique which also utilized aspects of psychoeducation. The goals of psychoeducation were to improve symptom recognition, adherence to treatment and psychosocial functioning. Results showed improvement in social functioning (i.e., family and employment), satisfaction with the group process and no re-hospitalizations were needed.

Psychoeducation regarding diagnosis or symptom identification is also an aspect of treatment used in treating depression and anxiety. McEvoy and Nathan (2007) conducted a study to evaluate the effectiveness for CBT psychotherapy groups for depression and anxiety. Results showed that symptoms of anxiety and depression significantly improved, as aspects of the treatment approach included psychoeducation about both depression and anxiety.

Neimeyer et al. (1995) studied inpatients diagnosed with major depression. The treatment approach consisted of many factors, one being education related to self help skills. Results showed that symptoms of anxiety and depression significantly improved. It seems reasonable to assume that being educated about self help skills and being educated about depression and anxiety will increase patient's awareness of symptoms. The previously mentioned study by Moffat et al. (1995) studied inpatients suffering from

symptoms of both depression and anxiety. One aspect of treatment was to help group members identify and label emotions. Groups also focused on learning how to have fun again. This helped patients become more aware of the relationship between engaging in enjoyable activities and their mood. As patients became better at labeling their emotions, it also seemed reasonable to assume that they became better at identifying symptoms of depression and anxiety as well.

Psychoeducation regarding diagnosis or symptom identification may also be a relevant aspect of the treatment for borderline personality disorder. The previously mentioned study by Hagan et al. (2005) utilized aspects of psychoeducation which included understanding psychological and behavioral symptoms. Although this study was not focused on borderline personality disorder alone, results showed a significant decrease in negativistic personality patterns. In addition, MCMI-III results also indicated that borderline personality patterns decreased at both post-treatment and at six months; however, these results were not significant.

Non-suicidal self-injury (NSSI) refers to the non-lethal intention to destroy body tissue (Nock & Favazza, 2009; Nock, Wedig, Janis, & Deliberto, 2008; Whipple & Fowler, 2011). Prevalence rates for this activity have been estimated to be as high as 90% among inpatients diagnosed with borderline personality disorder (Whipple & Fowler, 2011; Zanarini et al., 2008). Patients who engage in NSSI typically have great difficulty with emotion regulation and interpersonal communication (Whipple & Fowler, 2011). It seems reasonable to assume that helping patients with borderline personality disorder to recognize symptoms will aid in their emotional regulation and interpersonal skills. Therefore, it appears that most studies have placed some degree of emphasis on

symptom/diagnosis recognition for patients suffering from psychosis, mood disorders and borderline personality disorders. Helping patients identify stressful life events or triggers also appears to be a relevant factor in aiding their understanding of symptom onset and exacerbation.

Identifying triggers. There have been several life events, stressors and triggers associated with the onset or exacerbation of symptoms related to psychosis, mood disorders and borderline personality disorders. Several researchers have found it important to gain a more thorough understanding of these triggers in order to aid in the treatment of these disorders. For instance, teaching patients how to identify factors that trigger episodes of illness allows them to intervene early and reduce the number and duration of potential relapses (Geddes, 2003; Perry et al., 1999; Russell & Brown, 2004).

Psychosis can be influenced by various social environmental stressors such as critical comments, stress, and trauma. Authors have demonstrated that exposure to a traumatic event may increase the likelihood of developing psychotic symptoms. According to Mueser et al. (1998) a sample of psychotic patients reveled that 98% had been exposed to a traumatic event. Neria (2002) found that nearly 70% of psychotic admissions had experienced a traumatic event. The nature of the relationship between the schizophrenic patient and their family can play an important role in the onset, relapse and deterioration of psychotic symptomatology (Rosenfarb et al., 1995).

For example, Brown, Birley, and Wing (1972) found that schizophrenic patients with relatives who made frequent critical comments experienced faster relapse rates. A more recent study by Hahlweg (2005) discovered higher relapse rates for schizophrenic patients following hospital discharge when they had families who were emotionally over-

involved, lacked personal warmth and made frequent critical comments. Barrowclough et al. (2003) found that schizophrenic patients who evaluate themselves negatively experience an increase in positive symptoms. Exposure to stress in the form of stress-inducing thoughts or a hostile environment can also play an important role in the development of psychotic symptoms (Meijel et al., 2004).

Recent studies have found that psychosocial factors are important in predicting the course of bipolar disorder (Abramson et al., 2010; Miklowitz & Johnson, 2006). Life events centered on goal attainment have been found to increase symptoms of mania (Abramson et al., 2010; Johnson et al., 2000). Others have shown that negative life events trigger relapse into bipolar depression (Abramson et al., 2010; Alloy et al., 2005). In addition, stress has been found to trigger both symptoms of hypomania and depression. The forms of stress that have been found to trigger these symptoms include stressful family and personal relationships, employment issues, and other environmental factors. Disruption in sleep can also trigger both symptoms of hypomania and depression (Malkoff-Schwartz, 1998; Rasmana & Bebbington, 1995; Russell & Brown, 2004). Other factors identified that trigger episodes of illness included: fatigue, jet lag, hormonal fluctuations, seasonal change, excessive socializing, such as attending late-night parties, and substance abuse (Russell & Brown, 2004). Controlling bipolar disorder calls for patients to obtain insight regarding their personal triggers and warning signs, maintaining good sleep hygiene, finding suitable medication, reducing stress levels, and establishing support networks. In addition, they also benefit from establishing a 'stay well' plan and being mindful of their illness.

Regarding episodes of major depression, frequent and disruptive life events outside of the patient's control have been found to trigger episodes of major depression (Shrout et al., 1989; Ventura et al., 2000). In addition, individuals who are isolated had a tendency toward low self-esteem, a greater external locus of control, and feelings of insecurity, which led to more episodes of depression (Coleman et al., 1993; Regehr et al., 2000; Russell & Brown, 2004). A study by Moffat et al. (1995) utilized a psychoeducational approach for geriatric inpatients suffering from symptoms of both depression and anxiety. One aspect of the psychoeducational focus was to help group members' identify and label emotions. Groups also focused on learning how to have fun again. This helped patients become more aware of the relationship between engaging in enjoyable activities and mood (Moffat et al., 1995). It is reasonable to assume that this approach would also help patients suffering from anxiety and depression to become more aware of how stressful events or triggers influence their symptoms.

As previously stated, non-suicidal self-injury (NSSI) has high prevalence rates among inpatients diagnosed with borderline personality disorder (Whipple & Fowler, 2011; Zanarini et al., 2008). Patients who engage in NSSI typically have great difficulty with emotion regulation and interpersonal communication (Whipple & Fowler, 2011). NSSI behavior can be triggered by emotional upheaval, upsetting and misinterpreted interpersonal interactions (Safran & Muran, 2000; Whipple & Fowler, 2011). And as discussed, a study by Hagan et al. (2005) investigated a group therapy approach utilizing aspects of psychoeducation that focused on understanding symptoms, recognizing triggering stressful events and developing new coping mechanisms. Results demonstrated decreases in negativistic personality patterns, and also borderline personality patterns.

Therefore, several life events, stressors and triggers have been associated with the onset or exacerbation of symptoms related to psychosis, mood disorders and borderline personality disorder. Teaching patients how to identify factors that trigger episodes of illness allows them to intervene early and reduce the frequency and duration of relapses (Geddes, 2003; Perry et al., 1999; Russell & Brown, 2004). After patients are better able to recognize their symptoms and obtain a greater understanding of how those symptoms are exacerbated, it seems most relevant to offer assistance in coping or effectively dealing with those symptoms and triggers.

Coping skills. Conditions of stress call for coping resources in order for an individual to maintain mental health and overall well-being. Coping strategies that are broad, flexible and effective allow individuals to be most successful when dealing with stressful events. There are two types of constructive or positive coping strategies: emotion focused coping and problem focused coping. These strategies help regulate distressing emotions and make attempts to change the problems creating the distress. Most situations call for the utilization of both coping strategies (Lazarus & Folkman, 1984; Vollrath, Alneas, & Torgersen, 2003).

Examples of problem focused positive coping include active coping, planning and/or rearranging priorities. Examples of adaptive emotion focused positive coping strategies may include seeking social support, positive reinterpretation and religion (Carver et al., 1989; Vollrath, Alneas, & Torgersen, 2003). Clinical symptoms call for effective positive coping strategies in order to regulate emotional distress (Vollrath, Alneas, & Torgersen, 2003). However, individuals with clinical syndromes have been found to utilize maladaptive or negative coping strategies. Previous studies on psychiatric

outpatients have suggested that maladaptive or negative coping strategies may include: less problem solving, less information seeking, using less social support, wishful thinking, avoidance, rumination, substance use, holding anger in or even lashing out in anger, denial and disengagement, such as isolation or withdrawal (Borden, Clum, Broyles, & Watkins, 1988; Vitaliano et al., 1987; Vollrath, Alneas, & Torgersen, 2003; Vollrath & Angst, 1993; Billings, Cronkite, & Moos, 1983; Carver et al., 1989; Miller, Surtees, Kreitman, Ingham, & Sashidharan, 1985).

A study by Vollrath, Alneas, and Torgersen (2003) explored coping strategies in 239 psychiatric outpatients as measured by the MCMI-II symptom inventories and the COPE (a self-report inventory measuring coping strategies). The study looked at MCMI-II symptom scales of anxiety, somatoform, bipolar, dysthymia, substance abuse, thought disorder, major depression, and delusional disorder in relation to various coping strategies. Findings suggested that patients should be encouraged to reinterpret positively, be accepting, be humorous and seek emotional support from others. On the other hand, patients should be discouraged to deny, disengage (i.e., isolation or withdrawal), or abuse substances.

Other studies have identified various lifestyle factors that have helped patients stay well, such as: eating healthy, exercising, drinking less alcohol and caffeine, good sleep hygiene, spending time with loved ones, relying on various support networks, having quiet time, taking care of pets, managing stress, attending church, becoming a part of mental health/community groups and various clubs, utilizing health care professionals, laughing and taking medication. In addition, patients have also found it beneficial to learn

how to set limits and boundaries, and establish support networks that can help them recognize early warning signs (Russell & Brown, 2004).

Treatment approaches for a diagnostically heterogeneous group should theoretically be able to practically accommodate a range of diagnoses, symptoms and ego functioning (Brabender & Fallon, 1993). The psychoeducation topics that appear to be most practical and applicable for a wide range of diagnoses include: identifying symptoms, gaining awareness of triggers (e.g., stressful events) that lead up to symptom onset and exacerbation, and coping with triggers and symptoms (Duman, 2010; Gonzalez & Prihoda, 2007; Hagan et al., 2005; Vukov, Moore & Cupina, 2007). In addition, it is important for the inpatient psychotherapy group to have achievable goals. Yalom (2005) listed six such goals: engaging the patient in the therapeutic process, demonstrating that talking helps, problem spotting, decreasing isolation, being helpful to others and alleviating hospital related anxiety. Therefore, a process-oriented psychoeducational approach consisting of the aforementioned topics appears to be an efficient method to achieve realistic goals for the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group.

Chapter 3

Treatment Implications

Synthesis of Studies

In the United States, there is a current rise in admissions to psychiatric hospitals, and also a lack of research exploring inpatient group psychotherapy (Fitzsimmons et al., 2008; Kosters et al., 2006; Manderscheid & Atay, 2009). Diagnostically homogeneous therapy groups outperform therapy groups with mixed symptoms; however, due to managed health care, psychiatric hospitals have a reality of diagnostically heterogeneous groups (Burlingame et al., 2003; Brabender & Fallon, 1993). Psychiatric hospitals commonly admit patients with a range of diagnoses such as: psychotic spectrum disorders, major affective disorders and borderline personality disorder (Angstman & Schuldberg, 2009; Burlingame et al., 2003; Kosters et al., 2006; Manderscheid & Atay, 2009; Yalom, 2005). In addition, managed health care has also created rapid patient turnover in psychiatric hospitals. The composition of the inpatient therapy group changes daily. On average, patients may end up attending approximately three to five groups during an inpatient stay (Bilynsky & Lyke, 2001). The inpatient psychotherapy group that is characterized by diagnostic heterogeneity and rapid turnover calls for a cross sectional approach. This approach views the life of the group as a single session that is independent on learning from previous sessions. The heterogeneous group, however, does allow the therapist to be more flexible in their approach (Brabender & Fallon, 1993; Yalom, 2005).

As mentioned earlier, previous group therapy studies were conducted examining various treatment approaches for groups that were homogeneous with respect to diagnoses, longer-term duration and a mixture of inpatient and outpatient settings. A few

studies have been conducted examining diagnostic heterogeneity. However, brief duration was not considered, group composition was unclear, and little evidence for efficacy was provided. Ultimately, the orientation for the diagnostically heterogeneous inpatient psychotherapy group that appeared to emerge from these various studies is one that focuses on a combination of process and psychoeducation. Therefore, the inpatient psychotherapy group that is characterized by diagnostic heterogeneity and rapid turnover appears to call for a cross-sectional approach that focuses on both elements of process-oriented and psychoeducational group therapy techniques.

Process-Oriented Psychoeducation

As discussed earlier, process-oriented psychology is a way of working with the designs and structures of the conscious human experience. It allows a group leader the ability to study and interpret how an individual subjectively organizes and perceives their conscious experience, largely by focusing on the observer's perceptions of the movement of their own experience. There are aspects of a person's process for which they can and cannot identify with; for example, aspects of an individual's secondary process may influence their primary process (Szymkiewicz-Kowalska, 1999). Individuals in group psychotherapy are able to gain awareness and fully conceptualize 'here-and-now' interactions through the facilitation of the group process (Slife et al., 1989).

A group facilitator can 'sort' the issues around which members are identifying with by encouraging group members to share their points of view while listening for themes. 'Sorting' allows the group leader to structure the group topics or the emerging themes to better meet the needs of group members, such as the un-identified group processes (i.e., intrapsychic, interpersonal and group-as-a-whole) (Szymkiewicz-

Kowalska, 1999). This appears to be especially pertinent to the diagnostically heterogeneous group which calls for an approach that will apply to a wide range of individual and interpersonal processes.

In addition, it is important to restate the significance of an individual's process occurring in a three dimensional manner with respect to their relationships within the group. For example, process has also been defined as "the nature of the relationship between individuals who are interacting with one another" (Ettin & Vaughan, p. 178; Yalom, 1985). Others have elaborated by stating that this relationship can have a threefold aspect because it can be between the individual and intrapsychic process, between group members or group members and the group leader, such as the interpersonal process, or between the psychotherapy group as a collective whole (i.e., group-as-a-whole process; Ettin & Vaughan, 1987; Rice, 1969). In regards to the interpersonal process between both the group members and the group members with the group leader, quality process comments on behalf of the group leader offer strong explanation of here-and-now interpersonal relationships (Slife et al., 1989; Yalom, 1983). It seems reasonable to assume that quality process comments from the group leader that offer here-and-now explanations would benefit not only interpersonal processes but also intrapsychic and group-as-a-whole processes.

According to Yalom (2005), the therapeutic change that takes place during group therapy is a process that occurs through an interplay of human experiences called "therapeutic factors," (p. 1). It is important to restate Yalom's fourteen therapeutic factors as they relate to process-focused therapy: installation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group,

development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, guidance, self-disclosure, self-understanding and existential factors. The use of process techniques to allow for the emergence of these therapeutic factors may be further enhanced through the integration of psychoeducation.

Psychoeducational approaches are appropriate for the acute inpatient psychotherapy group because they allow for interventions to be time-limited and efficient (Ettin & Vaughan, 1987; Poey, 1985). Psychoeducation has been defined as didactic information on illness and how to cope with it (Pitschel-Walz & Bäuml, 2009). Others have even defined psychoeducation simply as general learning (Ettin & Vaughan, 1987). Psychoeducational therapy groups can have content or a topic that is organized around a variety of symptoms or problems (Ettin & Vaughan, 1987; Poey, 1985). The content or topic of a psychoeducational therapy group offers a framework that can hold the group together while providing a shape to the group's proceedings (Ettin & Vaughan, 1987). Although the traditional focus of the psychoeducational group is on content, the utilization of group processes have long been recognized to further psychoeducational causes (Ettin & Vaughan, 1987; Pratt, 1921).

"Process characteristics are an intrinsic and inevitable aspect of all groups no matter what their size or function." (Ettin & Vaughan, 1987, p. 178; Whitaker & Lieberman, 1964). Attention to group process is important in psychoeducation because it allows for relevant informational points to be selected. "The sophisticated use of process can lubricate, support and move the content along to the next informational point (Ettin & Vaughan, 1987, p. 178; Klein, 1985). In addition, imparting of information and installation of hope are two therapeutic group process factors that can both emerge in

group members when the group leader communicates educational points (Gonzalez & Prihoda, 2007; Yalom, 1995). The leader of the psychoeducational group needs to become skilled at balancing between the content or topic of the group and member reactions or processes (Ettin & Vaughan, 1987; Klein, 1985). The psychoeducational group considers both intellectual and emotional experiences (Cohn, 1969; Ettin & Vaughan, 1987).

The blending of process and content will create an educational experience that is engaging, personal and meaningful. Process should not be viewed as an interruption to learning but rather something that can facilitate the assimilation of information. In addition, group members have a need to discuss information that is imparted to them. This discussion will inevitably evoke various reactions from group members. Therefore, the utilization of process techniques must find a role in any psychoeducational group (Ettin & Vaughan, 1987). The psychoeducational group leader can aim to support and personalize the content or topic through utilization of the group process. The leader can also respond to the feedback and emotional needs of group members by relating their process back to the group topic (Ettin & Vaughan, 1987; Shaffer & Galinsky, 1974).

A process-oriented psychoeducational method is an appropriate treatment approach for the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group. It appears that using aspects of process and psychoeducation allows for a flexible approach that is able to be used with a wide range of pathology including, psychosis, mood disorders and personality disorders. There are six achievable inpatient group therapy goals as mentioned previously: (a) engaging the patient in the therapeutic process, (b) demonstrating that talking helps, (c) problem spotting, (d) decreasing

isolation, (e) being helpful to others and lastly, and (f) alleviating hospital related anxiety (Yalom, 2005). These goals can provide a framework in which to operate and apply a flexible cross sectional approach oriented towards process and psychoeducation.

A process-oriented treatment approach for the diagnostically heterogeneous psychotherapy group should focus on facilitating group process in order to enhance group interactions and group member engagement, both with each other and with the group leader (Daniels, 1998). The facilitation of group therapy process should occur through implementing crucial therapeutic group factors (Daniels, 1998; Vukov, Moore, & Cupina, 2007; Yalom, 1998). These group process factors can be implemented in the 'here-and-now' by including the group leader's personal reaction and judicial self-disclosure, and by offering an explanation for 'here-and-now' interpersonal relationships (Brabender & Fallon, 1993; Slife et al., 1989; Yalom, 1983). Implementing these process factors can also be done by emphasizing feedback and altruism, interpersonal skill development, and increasing self-awareness and self-understanding (Higgitt & Fonagy, 1992; Vukov, Moore, & Cupina, 2007; Yalom, 1998). In addition, it is important for group members to experience a supportive, empathic connection with the group leader (Brabender & Fallon, 1993; Higgitt & Fonagy, 1992). Others can benefit from restating the situation that may have led to their hospitalization, discussion of the situation within the group context, encouragement of healthier coping mechanisms and interactional patterns, and social reinforcement or advice-giving from the group as a new coping response (Whitaker & Deikman, 1980).

Treatment approaches for a diagnostically heterogeneous group should theoretically be able to practically accommodate a range of diagnoses, symptoms and ego

functioning (Brabender, 1993). The psychoeducation topics that appear to be most practical and applicable for a wide range of diagnoses include: identifying symptoms, gaining awareness of triggers (e.g., stressful events) that lead up to symptom onset and exacerbation, and coping with triggers and symptoms (Duman, 2010; Gonzalez & Prihoda, 2007; Hagan et al., 2005; Vukov, Moore & Cupina, 2007).

In addition, it is very important for the inpatient psychotherapy group to have achievable goals. As discussed in detail earlier and restated now in order to make clear the importance of these goals, Yalom (2005) includes: engaging the patient in the therapeutic process, demonstrating that talking helps, problem spotting, decreasing isolation, being helpful to others and alleviating hospital related anxiety. Therefore, a process-oriented psychoeducational approach consisting of process around the aforementioned topics appears to be an efficient method to achieve realistic goals for the acute inpatient, diagnostically heterogeneous, brief duration psychotherapy group.

Proposed Treatment Model

The following treatment recommendations are for the rapid turnover, short duration, diagnostically heterogeneous inpatient psychotherapy group. Recommendations are based upon a synthesis of inpatient treatment approaches represented in the literature and applied to rapid turnover, inpatient psychotherapy groups characterized by diagnostic heterogeneity, namely, psychotic spectrum, mood and borderline personality disorders.

It is recommended that the group leader adopt a flexible cross sectional approach (Brabender, 1993) oriented towards process and psychoeducation. This approach should operate with the following group therapy goals in mind: engaging the patient in the therapeutic process, demonstrating that talking helps, problem spotting, decreasing

isolation, being helpful to others and alleviating hospital related anxiety (Yalom, 2005). These treatment goals can be achieved by facilitating the emergence of Yalom's 14 therapeutic factors which allow for therapeutic change: installation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, guidance. self-disclosure, self-understanding and existential factors.

The emergence of these therapeutic factors can occur through facilitating group process in order to enhance group interactions and group member engagement, both with each other and with the group leader (Daniels, 1998). The therapeutic factors can also emerge through a supportive, empathic approach (Brabender & Fallon, 1993; Higgitt & Fonagy, 1992) which includes the group leader's personal reactions and judicial self-disclosure (Brabender & Fallon, 1993), and by offering an explanation for 'here-and-now' interpersonal relationships (Slife et al., 1989; Yalom, 1983). Implementing these process factors can also be done by emphasizing feedback and altruism, interpersonal skill development, and increasing self-awareness and self-understanding (Higgitt & Fonagy, 1992; Vukov, Moore, & Cupina, 2007; Yalom, 1998). Others can benefit from restating the situation that may have led to their hospitalization, discussion of the situation within the group context, encouragement of healthier coping mechanisms and interactional patterns, and social reinforcement or advice-giving from the group as a new coping response (Whitaker & Deikman, 1980).

Choosing psychoeducational topics allow for the intervention to be time-limited and efficient (Ettin & Vaughan, 1987; Poey, 1985). These topics can be didactic

information on illness and how to cope with it (Pitschel-Walz & Bäuml, 2009) or topics facilitating general learning (Ettin & Vaughan, 1987). These topics can be organized around a variety of symptoms or problems (Ettin & Vaughan, 1987; Poey, 1985). This offers a framework that can hold the group together while providing a shape to the group's proceedings. In addition, the utilization of group processes can further the psychoeducational cause (Ettin & Vaughan, 1987; Pratt, 1921).

Attention to group process allows for relevant informational points to be selected (Ettin & Vaughan, 1987). In addition, imparting of information and installation of hope are two therapeutic group process factors that can both emerge in group members when the group leader communicates educational points (Gonzalez & Prihoda, 2007; Yalom, 1995). The leader of the group needs to balance between the content or topic of the group and member reactions or processes (Ettin & Vaughan, 1987; Klein, 1985). The group leader needs to consider both intellectual and emotional experiences (Cohn, 1969; Ettin & Vaughan, 1987).

The blending of process and content can create an educational experience that is engaging, personal and meaningful. Process can facilitate the assimilation of information. In addition, group members have a need to discuss information that is imparted to them. This discussion will inevitably evoke various reactions from group members. Therefore, the utilization of process techniques remains important. The group leader can aim to support and personalize the content or topic through utilization of the group process. The leader can also respond to the feedback and emotional needs of group members by relating their process back to the group topic (Ettin & Vaughan, 1987; Shaffer & Galinsky, 1974).

The psychoeducation aspects or topics that appear to be relevant to a wide range of diagnoses include: identifying symptoms, gaining awareness of triggers (e.g., stressful events) that lead up to symptom onset and exacerbation, and coping with triggers and symptoms (Duman, 2010; Gonzalez & Prihoda, 2007; Hagan et al., 2005; Vukov, Moore & Cupina, 2007). A group facilitator can determine the issues around which members are identifying with by encouraging group members to share their points of view while listening for themes. 'Sorting' allows the group leader to structure the group topics or the emerging themes to better meet the needs of group members (Szymkiewicz-Kowalska, 1999). Although group topics may be pre-selected, the use of sorting allows for the flexibility to change the group topic to the most relevant issue at hand.

The brief duration, diagnostically heterogeneous, rapid turnover psychotherapy group warrants a process-oriented psychoeducational model. This model should provide opportunities for process while also providing psychoeducation regarding the identification of symptoms, and warning signs (i.e., triggers and stressful events) that lead up to a symptom exacerbation, and relevant coping strategies. This approach offers flexibility and is applicable to a wide range of symptoms, and levels of functioning. Another advantage to this approach is that it can be delivered in a cross-sectional manner where the life of the group is viewed as only a single session.

Process-Oriented Psychoeducation.

Treatment Model Outline:

A. *Orientation*: 2-5 minutes

1. Introduction
    a. Length of group (60 min)
    b. Group Rules
    c. Goals of group
    d. Confidentiality

B. *Check-in*: 5-15 minutes

1. Member Introductions
    a. First names
    b. Members describe a feeling
    c. Group leader remains supportive and validating
    d. Sorting (i.e., listening for themes)

C. *Process-oriented Psychoeducation* 35-40 minutes

1. Highlight symptomatic themes
    c. Ask patients to describe their symptoms
    d. Begin writing identified symptoms
    e. Encourage feedback among members

2. Ask members to describe Triggers
    a. Begin writing identified triggers
    b. Encourage feedback among members

3. Ask members to describe Coping strategies
    a. List coping strategies under positive or negative
    b. Relate coping strategies back to symptoms and triggers
    c. Encourage feedback among members

D. *Check-out 5-10 minutes*

1. Highlight relationships between symptoms, triggers and coping strategies.
    a. Reinforce positive interactions and interpersonal learning
    b. Ask members to describe how they feel currently
    c. Encourage development of personal stay well plan

Process-Oriented Psychoeducation: Suggested Treatment Model

Orientation (2-5 minutes). The group leader will introduce his/her self and state that the group will be 60 minutes long and discuss group rules for particular setting of group (e.g., no aggressive behavior or physical contact is allowed) (Yalom, 2005). Next, the purpose of the group should be stated, for example, "The purpose of this group is to help members learn more about communication, relating to others and identifying and coping with common psychiatric symptoms" (Yalom, 2005). In addition, group members should be informed that confidentiality is limited to the treatment unit and treatment team.

Check-in (5-15 minutes). During this time the group leader should go around the room and ask each member to introduce themselves by stating their first name and to talk briefly about how they are doing emotionally (i.e., get them to name and describe a feeling). During this time, the group leader should be supportive and validating (Brabender & Fallon, 1993; Yalom, 2005). This will begin to engage the patient in the therapeutic process by offering them an opportunity to feel understood, supported and validated (Yalom, 2005). This can also begin to facilitate the group therapy goals of engaging the patient in the therapeutic process, demonstrating that talking helps (i.e., through support and validation from the leader), problem spotting (i.e., helping the patient identify areas of work), decreasing isolation, and alleviating hospital related anxiety. These treatment goals begin being addressed through the facilitation of the therapeutic factors of universality, group cohesiveness, catharsis, self-disclosure, and self-understanding.

During the check-in phase the therapist should listen for themes through 'sorting' (Szymkiewicz-Kowalska, 1999). The check-in can also offer the therapist a chance to get to know the level of functioning and symptomatology that is present in the room. Spending time getting to know the group members allows the therapist to tailor the approach (Brabender, 1993). Contact, engagement and interaction grounds group members to the 'here-and-now' (Daniels, 1998; Serok & Zemet, 1983; Kanas, 1985). Therefore, the check-in process may allow members to be fully present and aware of the situation and capable of engaging in group discussion.

Process-oriented psychoeducation (35-40 minutes). After the check-in, the therapist should highlight any themes (i.e., anxiety, depression, etc.) that were present in any of the group members' experiences. The therapist should then ask if anyone can relate to the highlighted theme (e.g., "John said he felt very depressed. Can anyone relate to that feeling?"). In an attempt to build quick cohesion, allow patients the time, space and support to provide feedback to one another, and also to receive the feedback from others. Asking if other patients can relate to one another while allowing them space to offer feedback to one another can increase self-disclosure, group cohesion and universality. In addition this encourages catharsis while allowing for the development of socializing techniques, and instilling hope. The therapist can further facilitate universality, cohesion, and installation of hope by asking members "How does it feel to know that there are others in this room who feel depressed?" This aspect of the process phase highlights the group therapy goals of engaging the patient in the therapeutic process, demonstrating that talking helps, problem spotting, decreasing isolation, and alleviating hospital related anxiety. It is important to attempt to engage any patients who

may be actively psychotic. For instance, asking them if they can relate to what John said may help redirect and ground them to the group.

Questions can also be related back to the group topic (e.g., "John, how do you know when you are feeling depressed)? During this time, the therapist should use reflective listening while offering support and validation (Yalom, 2005). If patients begin to offer one another supportive feedback, highlight this and ask each member involved in the exchange how it felt. Allowing group process factors (i.e., cohesion, self-disclosure, instillation of hope) to emerge may allow members to be more aware of their emotional state, connect with others, feel validated and or grounded (Daniels, 1998; Serok & Zemet, 1983; Yalom, 2005). In addition, the therapist should look for opportunities to reframe cognitive distortions (Gonzalez & Prihoda, 2007; McEvoy & Nathan, 2007; Vukov, Moore, & Cupina, 2007). This aspect of the process phase highlights the group therapy goals of engaging the patient in the therapeutic process, demonstrating that talking helps, problem spotting, decreasing isolation, and alleviating hospital related anxiety. These treatment goals begin being addressed through the facilitation of the therapeutic factors of universality, the development of socializing techniques, interpersonal learning, group cohesiveness, catharsis, self-disclosure, and self-understanding.

If the group is able to establish quick cohesion and the process is becoming very therapeutic on a group level, the therapist should have the flexibility to allow group processing to continue for the entire hour (Brabender & Fallon, 1993). Otherwise, the group leader should move forward with psychoeducation, beginning with identifying symptoms. However, the therapist should also have the flexibility to change the topic if sorting revealed a more prevalent theme. The group leader should be prepared to move

forward by writing on a white board a few of the symptoms of depression, anxiety, or psychosis that have been identified by both the therapist and the patients. This can aid in learning, concentration and memory. Being able to view their symptoms may also provide important validation. The therapist should then explain the collection of symptoms that make up each particular diagnosis. The therapist should continue to implement process techniques by asking the group "Who else can relate to this symptom?" Or "Who else has experienced this?"

This highlights the group therapy goals of engaging the patient in the therapeutic process and helping them spot problems. This can help foster the therapeutic factors of universality, imparting information, catharsis, group cohesion, self-disclosure, and self-understanding. In the event where group members are unable or unwilling to engage the therapeutic process and have not offered any information after a period of time, the group leader should be prepared to move forward by writing down a few of the symptoms of common inpatient diagnoses for all group members to observe (see Table 1). This is a way to help the slow-to-process group begin to engage in the therapeutic process. For instance after writing down a few symptoms of depression or anxiety, the leader may begin asking some of the aforementioned questions such as "Who here has experienced some of these things?" The group leader can continue to impart information while asking open-ended questions in order to encourage the engagement of group members in the therapeutic process.

Table 1

Symptom Identification

Psychosis	Depression	Bipolar	Personality Disorder
Voices	Feeling Tired	Goal Focused	Fear of Abandonment
Paranoia	Weight Loss	Lack of Sleep	Intense Anger
Unrealistic beliefs	Crying	Risk Taking	Unstable Relationships

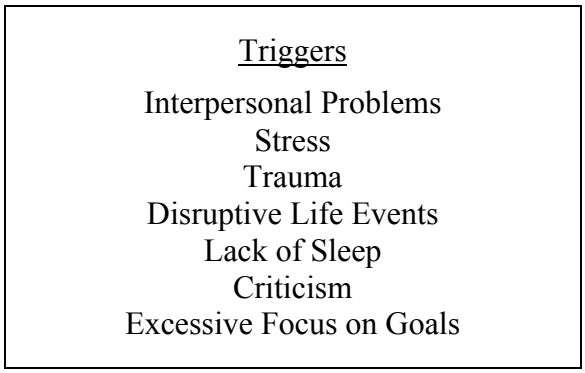
(Adapted from: DSM-IV-TR, 2000; Duman, 2010; Gonzalez & Prihoda, 2007; Hagan et al., 2005; Vukov, Moore, & Cupina, 2007).

In an attempt to build quick cohesion, allow patients the time, space and support to provide feedback to one another, and also to receive the feedback from others. Asking if other patients can relate to one another while allowing them space to offer feedback to one another can increase self-disclosure, group cohesion and universality. In addition this encourages catharsis while allowing for the development of socializing techniques, and instilling hope.

Next, the therapist should proceed by asking if patients can identify what types of situation, stressful events, behaviors or thoughts precede or exacerbate their symptoms. Patient's responses should also be written to be observed by all group members under the title of 'triggers' (see Figure 1). Again as patients provide responses the therapist should ask the other group members "Who else has experienced this?" Patients will not only begin to relate to another but will also gain greater awareness about what exacerbates their symptoms. In addition, this can engage the patient in the therapeutic process, demonstrate that talking helps, problem spot, and decrease isolation. Therapeutic factors can also emerge such as: universality, imparting information, interpersonal learning, group cohesiveness, catharsis, self-disclosure, and self-understanding. In an attempt to

build quick cohesion, allow patients the time, space, and support to provide feedback to one another, and also to receive the feedback from others. Asking if other patients can relate to one another while allowing them space to offer feedback to one another can increase self-disclosure, group cohesion and universality. In addition this encourages catharsis while allowing for the development of socializing techniques, and instilling hope.

In the event where group members are unable or unwilling to engage the therapeutic process and have not offered any information after a period of time, the group leader should be prepared to move forward by writing on a white board a few examples of triggers. This is a way to help the slow-to-process group begin to engage in the therapeutic process. For instance after writing down a few triggers related to depression or anxiety, the leader may begin asking some of the aforementioned questions such as "Who here has experienced some of these things?" The group leader can continue to impart information while asking open-ended questions in order to encourage the engagement of group members in the therapeutic process.



(Adapted from: Abramson et al., 2010; Hahlweg, 2005; Johnson et al., 2000; Mueser et al., 1998; Safran & Muran, 2000; Shrout et al., 1989; Ventura, et al., 2000; Whipple & Fowler, 2011).

Figure 1. Triggers

Then, the therapist should proceed by asking members how they have dealt with their triggers and symptoms. Patient's responses should also be written for all group members to observe under the titles of 'Positive Coping,' and 'Negative Coping' (see Figure 3). Again as patients provide responses the therapist should ask the other group members "Who else has utilized this coping technique?" Patients will not only begin to relate to another but will also gain greater awareness about what coping techniques have been helpful or unhelpful. In addition, this can engage the patient in the therapeutic process, demonstrate that talking helps, problem spot, being helpful to others, alleviate hospital related anxiety and decrease isolation. Therapeutic factors can also emerge such as: instillation of hope, altruism (patients may begin to offer one another advice), universality, imparting information, interpersonal learning, development of socializing techniques, group cohesiveness, catharsis, self-disclosure, self-understanding, guidance and existential factors. In an attempt to build quick cohesion, allow patients the time,

space and support to provide feedback to one another, and also to receive the feedback from others. Asking if other patients can relate to one another while allowing them space to offer feedback to one another can increase self-disclosure, group cohesion and universality. In addition this encourages catharsis while allowing for the development of socializing techniques, and instilling hope.

In the event where group members are unable or unwilling to engage the therapeutic process and have not offered any information after a period of time, the group leader should be prepared to move forward by writing on a white board a few examples of positive and negative coping mechanisms. This is a way to help the slow-to-process group begin to engage in the therapeutic process. For instance after writing down a few examples of coping mechanisms, the leader may begin asking some of the aforementioned questions such as "Who here has used some of these techniques?" The group leader can continue to impart information while asking open-ended questions in order to encourage the engagement of group members in the therapeutic process.

Table 2

Coping Mechanisms

Positive Coping	Negative Coping
Seeking Social Support	Isolation
Humor	Substance Abuse
Acceptance	Denial
Reinterpret Positively	Wishful Thinking

(Adapted from: Russell & Brown, 2004; Vollrath, Alneas, & Torgersen, 2003).

Check-out (5-10 minutes). This phase should highlight the general relationship between psychiatric symptoms, triggers and coping mechanisms. It is also to reinforce

positive interactions within the group. For example, “John I noticed that you smiled when Sarah said he knew how you felt.” Fostering interpersonal connections, altruism and that talking helps could be done by following up with “What made you smile?’ Or “Sarah, how does it feel to you made John smile?” Other gestures and aspects of body language should also be commented on in order to help members gain more self understanding. These comments can be done throughout the course of the group and do not have to wait for the end. In addition, members could be asked how they feel when they engage in positive coping mechanisms. This may help to instill hope. Finally members should be encouraged to continue to engage in maintaining greater self understanding and utilizing positive coping mechanisms upon release from the hospital. It should be suggested that members make their own personal stay well plan (Russell & Brown, 2004) in light what they learned in group. In addition, members should be encouraged to continue addressing newly identified problems through ongoing treatment.

Clinical Implications

Acute inpatient psychotherapy groups are increasingly heterogeneous with respect to diagnosis, ego functioning and psychosocial functioning. It is not uncommon to have patients with a variety of diagnoses including psychosis, bipolar, severe depression and borderline personality disorder all within the same group. Due to changes in managed health care, treatment is expected to be brief and effective. Therefore, acute, inpatient psychotherapy groups that are diagnostically heterogeneous and have a rapid group member turn over is constantly in flux not only in terms of membership but also presenting problems. This type of group offers challenges to the traditional views and methods of conducting group psychotherapy.

Although arguments can be made for the benefits of heterogeneous groups, the majority of research indicates that homogeneous groups are better for cohesion. In addition, traditional homogeneous groups allow for easier goal definition and structuring of sessions. In addition, structured learning that is dependent upon previous sessions does not apply well to groups with greater heterogeneity, rapid turnover, and a constant flux of membership and presenting problems. To make matters more complex there is very little guidance found in the literature about how to facilitate these types of groups let alone information regarding treatment efficacy. Therefore, the acute inpatient psychotherapy group creates a challenging therapeutic environment for the group leader to facilitate treatment. The proposed process-oriented pschoeducational model provides a guiding framework for clinicians leading these types of groups. In addition, it is hoped that this model will aid in allowing for a theoretical starting point in terms of studying and learning more about treatment efficacy.

The advantages of the process-oriented psychoeducational model include its flexibility, relevance to a wide range of symptomatalogy and ego functioning, and ease of implementation. This model offers a process-oriented psychoeducational approach that may be best suited to target and provide treatment for a range of symptoms in a time-limited fashion. In addition, this approach has promising potential to create quick cohesion and universality, two important group therapeutic factors that are challenging to foster for a brief duration, heterogeneous group. The check-in phase combined with the use of sorting (i.e., identifying themes) (Szymkiewicz-Kowalska, 1999) also offers flexibility for the group leader to choose a topic of discussion that may be most relevant to the group members. Other psychoeducational topics that may be useful to explore

include: medication management, anger, suicidality, warning signs, relapse prevention, and aftercare plans.

Using process techniques centered around psychoeducational topics offers greater opportunity for the brief, heterogeneous group to achieve the realistic inpatient goals identified by Yalom (2005) (i.e., engage the patient in the therapeutic process, demonstrate that talking helps, allow patients to problem spot, decrease isolation, being helpful to others and relieve hospital related anxiety). In addition, using process techniques centered around psychoeducational topics offers greater opportunity for the brief, heterogeneous group to foster several of Yalom's therapeutic or curative factors necessary for change (i.e., installation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, guidance. self-disclosure, self-understanding and existential factors).

Inpatient psychotherapy groups can be facilitated by a wide range of professionals from different disciplines. The process-oriented psychoeducational model offers an approach that is practical for professionals from various disciplines to implement. The elements of process techniques and psychoeducational topics (i.e., identifying symptoms, triggers and coping) used are common factors found to some degree in nearly all treatment modalities and approaches. Therefore, it seems likely that most professionals have received at least some element of training and are comfortable with both process-oriented and psychoeducational techniques. Although the brief, heterogeneous inpatient group presents a complex treatment scenario, it appears as that the solution may involve a more simplified and general approach.

The limitations of this approach as applied to this setting, may relate to measuring effectiveness (Kosters et al., 2006). The inpatient setting presents a number of contributing variables that may be contributing to a patient's improvement or lack thereof. Identifying these variables, measuring them and explaining how much of the variance each variable accounts for becomes complex as many others have pointed out (Fuhriman & Burlingame, 1994; Kosters et al., 2006). This becomes even more complex when measuring effectiveness for the brief duration, rapid turnover, heterogeneous inpatient group. This may very well explain the lack of research in this area. However, the process-oriented psychoeducational approach may also present opportunities to learn more about effectiveness. This could include surveys measuring the fostering of the curative or therapeutic factors and achievement of inpatient goals. In addition, surveys could measure understanding or awareness of psychiatric symptoms and triggers, coping strategies. Analyzing data regarding re-hospitalization rates may also provide further insight regarding effectiveness.

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Appendix A

Author's Clinical Observations

The present author spent one year of clinical training facilitating approximately 250 adult (aged 18-55) inpatient psychotherapy groups at a private psychiatric hospital located in a western state. Observations during this experience inspired the current study. The psychotherapy groups conducted were diagnostically heterogeneous. Typical diagnoses observed within the group psychotherapy members included psychotic spectrum disorders, major depressive disorder, borderline personality disorder and bipolar disorder. It was common to have lower functioning actively psychotic and manic patients alongside more high functioning patients suffering from severe depression. The composition of these psychotherapy groups changed on a daily basis. Therefore, nearly every group conducted consisted of a different subset of patients and diagnoses.

A review of the research literature was conducted in order to locate empirical studies that could offer treatment recommendations regarding how to facilitate brief duration, diagnostically heterogeneous inpatient psychotherapy group. The review of the literature in this area revealed little information about this specific type of group. Therefore, the current study aimed to offer treatment recommendations on how to facilitate a diagnostically heterogeneous psychotherapy group demonstrated through a synthesis of the research literature in the area of inpatient group psychotherapy.