TIME-LIMITED GROUP PSYCHOTHERAPY: A CASE REPORT

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The financial difficulties which many mental health agencies now face make it more important than ever that cost-efficient treatment modalities are utilized as much as possible. One modality which utilizes professional time efficiently is time-limited group psychotherapy.

A review of the literature on time-limited group psychotherapy reveals that there have been few case reports of actual clinical experiences with this approach (e.g., Sadock & Gould, 1964; Karson, 1965; Sadock et al., 1968; Trakas & Lloyd, 1971). The present paper is designed to summarize our experience with one particular time-limited group. The mechanics of setting up and running the group will be detailed, and the data collected regarding the effectiveness of the group will be reported.

Patient Selection

The group was conducted by the first and supervised by the second author. Members of the hospital staff were apprised that the group was being formed and referrals were made on the basis of intake interviews.

When an individual was referred, a screening interview was arranged with the therapist. It was decided to exclude suicidal, addicted, acutely psychotic and sociopathic individuals from the group, as well as any patient who was likely to be a deviant and therefore prematurely drop out or take up an inordinate amount of group time (Yalom, 1970). Patients who seemed to have some ability to, and interest in, utilizing their observing egos to look at themselves and their problems were encouraged to participate. Of those patients screened, one person did not want to participate and two were thought to be inappropriately referred. The therapist contracted with six patients for treatment.

The first part of the screening interview consisted of a discussion of the patient's motivation for treatment and identification of those issues with which the patient was particularly concerned. Patient 1 was a male in his mid-40's whose wife had just left him and whose self-esteem was severely shaken. Patient 2 was a male in his mid-30's who felt constricted in terms of his ability to recognize and express most of his feelings, though he was clear about being angry that others did not respond to his needs. Patient 3 was a female in her early 30's who was depressed and unable to communicate effectively with her husband. Patient 4 was a women in her late 20's

who was frightened of her anger at her child and felt quite isolated from others. Patient 5 was an obese woman in her late 20's who was significantly depressed about her loneliness and inability to establish successful relationships with others. Patient 6 was a woman in her late 20's who was involved in a number of obviously destructive sadomasochistic relationships with men.

Patient Preparation

The second part of the screening interview consisted of a careful preparation of each of the patients who had contracted for treatment. The therapist made it clear that the group would last for ten sessions and helped each patient to specifically define goals that could be attained within that time period. There was discussion of the importance of active participation because of the limited time available. An effort was also made to deal with patients' unrealistic expectations, fears and resistances concerning entering a group and exposing their problems to other people whom they did not know. The importance of confidentiality was stressed. Finally, the notion that a group is a place where people can learn about themselves, especially in terms of how they relate to others, was conveyed. It was suggested that looking at the ways in which people in the group related to one another might assist the members in learning how they related to other important people in their lives.

Questionnaires

At the end of the interview, each patient was given two brief questionnaires to complete. The first measure was the "Self Attitude Questionnaire", a 22-item instrument which assesses self-esteem (Landy and Sigall, 1971). Respondents indicate on five-point scales how characteristic or uncharacteristic each self-descriptive statement is for them. Split-half and alternate form reliabilities for this instrument range between .81 and .87.

The second instrument utilized was a "Goals Survey", an unpublished questionnaire designed to assess the goals an individual has before beginning a group experience, the extent to which these goals change over the course of the group and the extent to which individuals believe they have accomplished their goals (both original and final) at the conclusion of the group. Initially, patients are asked to choose three goals which most accurately characterize their therapy objectives. Secondly, for each of the three goals selected, the individual is asked to specify a "behavioral criterion" which can be used to test whether the goal has been reached at

the end of the group. The "Goals Survey Follow-Up", given during a post-group evaluation interview, assesses how many of the three goals have been reached, in accord with the specified behavioral criteria.

The third instrument employed to assess the impact of the group consisted of two forms from the Katz Adjustment Scale (Katz & Lyerly, 1963), an instrument of demonstrated reliability and validity. These forms require that significant others in patients' lives rate the frequency with which they perform various behaviors. The first form employed concerns the patients' symptomatology and social behavior (e.g., "looks worn out," "has strange fears," "is dependable," "talks too much," etc.). The second form focuses on the patient's performance of socially expected activities (e.g., "helps with household chores," "visits his relatives," etc.)

During the pre-group interview, patients were asked to specify two people in their lives who knew them very well and who would be willing to complete two questionnaires about them (pre- and post-group). The therapist then mailed the questionnaire (combining the two forms used) to these people with a brief covering letter indicating that the patient had given permission to have the respondent answer questions about him/her. Respondents were assured that the patient would not be informed of their answers and were asked for honest and prompt replies. At the conclusion of the group, the questionnaire was again distributed.

Therapy Strategy

The group was conducted for one hour per week for ten consecutive weeks. The group began with six patients, but one dropped out after the third session. Thus, only five patients remained in the group until its conclusion. Attendance throughout the 10-week period was quite good; though a patient would occasionally miss a session, some of the patients attended all of the sessions and all of the patients attended at least eight of the 10 sessions.

The following constitutes the therapeutic strategy adopted with each of the five patients who completed the group:

Patient 1—The therapist empathized with the painful loss sustained by this patient and the narcissistic injury it caused. However, the therapist also confronted the patient directly about his overbearing interpersonal style, which clearly had played an important role in the dissolution of his marriage. Furthermore, the patient was encouraged to see that his alternating pleas for help and expressions of resentment toward those who tried to help were a reflection of his ambivalence and confusion about

dependency and significant time was spent exploring how this too had played an important role in the unravelling of his marriage.

Patient 2—At first this patient's helpfulness was appreciated by the therapist, but he soon came to realize that this was used by the patient to avoid acknowledging his own difficulties and neediness. As the patient continued to focus on other members' problems, the therapist pointed out to him that he would continue to find others unresponsive to his needs as long as he did not find ways to make his needs known and he persisted with this theme every time this patient attempted to help another patient (or the therapist himself).

Patient 3—The therapist quickly noticed that this patient assumed a child-like posture in relation to the other group members. This elicited parental responses from a number of the others, which simply served to confirm her feelings of helplessness and worthlessness. The patient was strongly encouraged to recognize this pattern and thereby to take responsibility for her depression, in contrast to the "helpless victim" posture she had assumed at the outset of the group. The therapist decided not to work directly on this patient's relationship with her husband because of his sense that there was not enough time to make meaningful inroads into what seemed to be a deeply entrenched pathological pattern of relating.

Patient 4—This patient also assumed a submissive, child-like posture in relation to the other group members, but responded with anger rather than depression to the nurturing, care-taking behaviors she elicited from others. In addition to pointing out her responsibility for the way others typically responded to her, the therapist encouraged her to accept and express her angry feelings directly, rather than to displace them onto her child.

Patient 5—Once again the therapist focused on this patient's interpersonal style: she would act withdrawn and depressed, subtly inviting others to reach out to her. When they did so, she would over-react by engaging in narcissistic monologues about her travail which would elicit anger and pity from others, but not genuine warmth. She was encouraged to be assertive but not overly indulgent and responded dramatically to this feedback and encouragement.

In general, the therapist's interventions during the ten weeks differed substantially from conventional (time-unlimited) group psychotherapy. Specifically, he tended to focus on the limited goals which had been agreed upon during the screening interview, even when other issues emerged that could have received attention. There was certainly some adjustment and re-definition of goals over the course of the ten weeks, but such changes were relatively minimal. He concentrated on the patients' immediate needs and concerns, and spent relatively little time delving into

the past seeking to uncover the roots of present difficulties. Interpretations were formulated by him and shared with patients much more quickly than in time-unlimited psychotherapy. Of course, the therapist looked for and attempted to respond to any cues which indicated that a patient was simply not ready to deal constructively with a particular area; but there was more risk-taking on the part of the therapist than in more conventional psychotherapy. Furthermore, the therapist's interventions were at times lengthier than they would have been in other circumstances; he went further in spelling out and elaborating his interpretations than he would have in longer term therapy; at times he gave behavioral prescriptions as to how the patient might seek to bring about a change in the area under discussion. Finally, the therapist sought to be more supportive than he would have been otherwise. He directly urged patients to try out different behaviors, communicating his belief that patients had the necessary resources to make the requisite changes in their lives. His strategy was to increase the patients' beliefs that they could exert substantial control over the course of their lives (Gillis & Jessor, 1970).

Termination

The issue of termination pervaded the group sessions from the first week onward. The patients were frustrated at having such a limited amount of time allotted to them, and were able to express their anger about this with increasing directness as the weeks went by. The therapist recognized the reality component of their feelings, but also made confrontive interpretations when he believed these feelings were being used to avoid doing therapeutic work.

At the conclusion of the 10-week period, the therapist met with each patient individually for a post-group evaluation of what progress had been made as a result of the group experience and to discuss whether further treatment was indicated. Reference was made to the goals which each patient had set during the screening interview; an attempt was made to assess to what extent each goal had been accomplished. The directive approach was extended into the post-group interview, in that the therapist often made explicit suggestions as to what kinds of behaviors were likely to result in the consolidation or advancement of whatever therapeutic gains had been realized.

Evaluation

All five patients who participated throughout the group expressed general satisfaction with the experience during their post-group interviews.

Patient 1, though stating that he felt he had benefited somewhat, was, on balance, least satisfied. He had not been able to convince his wife to end their separation, and had still not come to terms with beginning a new life for himself. Patient 2 was quite pleased with the group, stating that he was much better able to identify and give expression to his feelings and desires, especially in the context of his relationship with his wife. Patient 3 stated that she found the group quite useful in terms of helping her appreciate that she bore some of the responsibility for her feelings of depression, and that she had behavioral options she had not been aware of previously. Patient 4 was very satisfied with the group experience, stating that she had become more comfortable with her angry feelings, less punishing of her child, and more satisfied in her relationships outside her marriage. Patient 5 felt that she had made enormous progress, felt less depressed and more adequate in dealing with her family, and was better prepared to have meaningful relationships with peers, both male and female. Patient 6 left the group after the third session, and did not want to participate in a post-group interview.

The five patients who completed the group agreed with the therapist that further treatment was not indicated at that time. Where there were still clearly unresolved issues, it was agreed that the patient should try to work with what had been learned from the group experience before becoming involved in any additional treatment.

At the conclusion of the post-group interview, each patient again completed the "Self Attitude Questionnaire" and also filled out the "Goals Survey Follow-up." On the former instrument, the highest possible score is 110. For the five patients who completed the group, the mean pre-group score was 64.6, while the mean post-group score was 71. Though the data cannot be discussed in terms of statistical significance, the participants seemingly experienced some gain in the area of self-esteem. Of the 15 goals specified during the pre-group interview (three for each of the five patients who completed the group), the patients felt they had attained 10 of them, for a mean of two out of three.

One complete set of the Katz Adjustment Scale (pre and post) was received for each of the five patients who completed the group. On the first form, which assesses symptomatology and social behavior, scores range from 0 to 254; the lower the score, the more well adapted the patient appears to the respondent. The mean pre-group score was 66, while the mean post-group score was 44. On the second form, which assesses the performance of socially-expected activities, scores range from 0 to 32; the higher the score, the more frequently the respondent perceives the patient as performing these behaviors. On this form, the mean pre-group score was 20.8, while the mean post-group score was 24. These data suggest

that the patients' own perceptions of self-improvement over the course of the group were shared by significant others in their environment.

Conclusion

Insufficient numbers of patients and the lack of experimental controls and long-term follow-up measures make it necessary to state our conclusions with qualifications. However, the data suggest that immediate improvement can be gained from participation in groups of quite short duration. This conclusion is supported by the recipients of the treatment as well as by significant others in their environment.

Society's urgent mental health needs require that services be made available to greater numbers of people than have traditionally been served by mental health agencies. Mental health professionals are seeking to accomplish this end by offering traditional services in more efficient ways and by developing new and different models of intervention. Time-limited group psychotherapy is an excellent example of the first strategy; our experience is encouraging in that it suggests that this approach offers the prospect of bringing about meaningful change in an economic fashion. Hopefully, additional research can further refine the ways in which this modality can be used most effectively.

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