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## Patient Activity and Outcome in Group Psychotherapy: New Findings

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### ABSTRACT

*The relation of patient verbal activity to pretherapy symptom status and outcome was examined for ninety patients in time-limited group psychotherapy. For each half-hour segment the most verbally active member, or main actor (MA), was identified. Verbal activity was measured by counting the number of times each patient was MA during the course of the group. Outcome was assessed by administering a battery of instruments pre- and posttherapy and by obtaining direct ratings of patient benefit from the patient, therapist, and an independent rater: the number of times MA was found to be significantly correlated with four pretherapy measures, indi-*

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*cating that the most disturbed patients were most active in these groups; the number of times MA was also correlated with patient and therapist benefit ratings, indicating that therapists and patients themselves agreed that those who spoke the most benefited the most. However, partial correlations between number of times MA and other outcome measures did not produce any significant relationships. Thus, it does not appear that patient verbal activity is related to outcome, as measured by objective instruments.*

It is a widely shared assumption of group psychotherapists that the more verbally active a group member is, the better his or her outcome. Yalom (1985) forcefully maintains that this is the case for both short- and long-term group treatment. Citing his earlier work on encounter groups (Lieberman, Yalom, and Miles, 1973), Yalom (1985) writes: "the more active and influential a member was in the group matrix, the more likely he was to benefit" (p. 385). Further, in discussing long-term group therapy, he states: "the silent patient does not profit from the group. The greater the verbal participation, the more the patient is valued by others and ultimately by himself" (p. 385).

Other findings have supported Yalom's convictions about the relationship between activity and outcome. Lundgren and Miller (cited in Yalom [1985]) found that in sensitivity training groups the more words spoken by the participant, regardless of what was said, the greater the self-reported change. Orlinsky and Howard (1986) reviewed five studies (Yalom, Houts, Zimberg, and Rand, 1967; Di-Loreto, 1971; Scher, 1975; Sloane, Staples, Cristol, and Yorkston, 1975; McDaniel, Stiles, and McGaughey, 1981) regarding patient talk and outcome in psychotherapy. Only one study (Yalom, et al., 1967) pertained to group therapy. Overall, they found the amount of patient activity to be significantly related to outcome.

The present study was an attempt to reexamine the question of patient activity and outcome in group treatment. Patient activity was defined in terms of the frequency with which the patient was the most verbally active member in a given half-hour segment of the group. Using a varied outcome battery which examined patient change from a variety of perspectives, we sought to clarify the questions of "who is active in group treatment?" and "to what types of change does activity contribute?"

## METHODS

### *Groups and Members*

Our sample consisted of twelve, time-limited, fifteen-session outpatient psychotherapy groups from the Harvard Community Health Plan (HCHP). Although the original study sample had consisted of thirteen groups, one group was dropped from the analysis. This group had an extremely aberrant course with one member becoming psychotic during the treatment. In addition, the therapist had to be away for one month, interfering with the group's continuity. By the end of treatment five of eight members had dropped out. Because of the nonrepresentative nature of this group's experience, it was decided to exclude it from the current analyses.

The groups in this study were generally run in accordance with a model for time-limited group therapy developed by Budman and his colleagues (Budman, Bennett, and Wisneski, 1980; Budman and Bennett, 1983; Budman and Gurman, 1988). This approach, called an "adult developmental model" of time-limited group therapy, emphasizes the members' examination of common age-related themes, such as intimacy for young adults. Therapists are encouraged to be active and to generally maintain a here-and-now focus. The time-limited nature of the treatment and members' reactions to this limit are also explored.

Six therapists were the leaders for the groups studied. Each led two groups, except for one who led three. The therapists were experienced short-term group therapists. Two were psychiatrists, two were psychologists with doctoral degrees, and two were psychiatric nurses. There were three male and three female leaders.

Members of the study groups were ninety nonpsychotic male and female young adults, between the ages of twenty-one and thirty-five, who had sought therapy at the mental health department of a large health maintenance organization (HMO) in which they were enrolled. Table 1 provides demographic information regarding the study sample. Because the majority of patients seen at the HMO received such coverage through their employer, this was, for the most part, a working population. Symptomatically, they tended to be depressed and/or anxious. Although none were taking antidepressant or anti-anxiety medications at the time of enrollment in the study, some had done

TABLE 1  
Demographic Characteristics of Study Sample

Demographic Variable	Percent of Sample (n = 90)
<i>AGE</i>	
Mean age:	27.9 yr
<i>SEX</i>	
Female:	60.7%
<i>RACE</i>	
White:	97.8%
<i>MARITAL STATUS</i>	
Single/Never Married:	72.2%
Married or Cohabiting:	20.0%
Separated or Divorced:	7.8%
<i>EDUCATION</i>	
H.S. or Some College:	12.2%
College Graduate:	87.8%
<i>RELIGIOUS PREFERENCE</i>	
Protestant:	22.2%
Catholic:	34.4%
Jewish:	27.8%
Other:	10.0%
None:	5.6%
<i>PREVIOUS THERAPY</i>	
Some:	82.0%
None:	18.0%

so in the past. On the Global Scale of the SCL-90-R, a widely used measure of psychiatric symptomatology, the average for our population fell near the 50th percentile when compared to adult psychiatric outpatient norms (Derogatis, 1977).

Six of the groups in this study were part of a randomized clinical trial of time-limited individual versus group psychotherapy (Budman, Demby, Redondo, Hannan, Feldstein, Ring, and Springer, 1988), while referrals to the other six groups were the usual clinical procedures of HCHP. The comparative outcome study found that both treatment modalities were equally effective, with significant improvement and maintenance of improvement for patients in each treatment. For example, the group treatment led to a mean improvement effect size on the various outcome measures of .91, approximately equal to that reported for all psychotherapies by Smith, Glass, and Miller

(1980). The degree of improvement experienced by the patients in the nonrandomized groups was slightly greater than that for the groups reported on by Budman, Demby, et al. (1988). These groups were thus effective in bringing about patient improvement.

Patients were briefed about the nature of the study. Those who agreed to participate were asked to sign informed consent material. At that point participants completed an extensive battery of outcome measures and interviews prior to joining the group. Immediately after the last group session, members again completed the outcome battery and interviews. An attempt was made to videotape all of the therapy groups in their entirety.

#### *Outcome Measures*

The battery of outcome measures used in this study included self-report instruments, observer rated scales, and therapist ratings. The following scales were among those used: (1) patient rated benefit (PRB); (2) therapist rated benefit (TRB); (3) independent interviewer rated benefit (IRB); (4) Coopersmith Self-Esteem Inventory (CSE) (Coopersmith, 1967); (5) UCLA Loneliness Scale (UCLA); Russell, Peplau, and Ferguson, 1978); (6) Global Assessment Scale (GAS); Endicott, Spitzer, Fliess, and Cohen, 1976); (7) severity of the first target problem from the Battle Target Problem Measure (SEV); (Battle, Imber, Hoehn-Saric, Stone, and Frank, 1966); (8) Social Adjustment Scale Global Score (SAS-Global) (Weissman and Paykel, 1974); (9) Global subscale of the SCL-90-R (SCL-90) (Derogatis, 1977); (10) Self-Motivation Inventory (SMI) (Dishman and Ickes, 1981).

#### *Patient Activity Measure*

Videotapes of the ninety-minute group therapy sessions were divided into three half-hour segments. These thirty-minute taped segments were then randomized and rated by three undergraduate students to determine who was the single most verbally active member of the group during a given segment. For the thirty-seven segments in which two raters selected the MA the agreement was 100 percent. For fifty of the segments, our raters were asked to indicate their confidence level for MA ratings; not once did they indicate even "some uncertainty." Thus, it is clear that MA ratings can be made readily, with

great reliability. The number of times a member was MA (number of times MA) ranged from 1 to 16 (mean = 6.07).

## RESULTS

In order to investigate the correlates of group member activity level, the number of times MA was correlated with each of the pretherapy measures in the outcome battery. The results of these analyses are contained in Table 2. The number of times MA was related to four of these variables, namely CSE, UCLA, SCL-90, and SMI. In every case, the direction of the relationship was such that higher pretherapy disturbance was related to greater patient activity.

The other question examined was the relationship between number of times MA and therapeutic outcome. The outcome measures were of two types: the direct benefit ratings, which were only obtained posttherapy (PRB, TRB, and IRB), and those change measures which assessed patient status both prior to and following therapy (all others).

The relation between activity and rated benefit was assessed by correlating the posttherapy benefit ratings with the number of times MA. For the prepost therapy change measures, the relationship between activity and patient change was assessed using partial correla-

TABLE 3  
Pearson Correlations of Patient Activity and Benefit Ratings

Variable	Number of Times MA
PRB	.26*
TRB	.25*
IRB	.03

Note: Positive correlation indicates positive relationship between rated benefit and activity. Ns are as follows: PRB—74; TRB—81; IRB—64.

\* $p < .05$

tions, with the pretherapy score on the measure partialled out of both variables.

As can be seen in Table 3, number of times MA was related to PRB and to TRB. Those patients who were more active tended to feel that they had gained greater benefit from the group, and were judged as having benefited more by their therapists. There was, however, no relationship between activity and the independent rater's benefit judgment or any prepost change measure.

## DISCUSSION

The two central findings in this study are that: (1) more troubled patients at the start of the group appeared to be the most likely MAs during the course of the group; and (2) higher levels of patient activity were correlated with "subjective" measures of benefit, as rated by both patients and therapists at the end of the group, but patient activity was not related to any "objective" (pre- and post-) measure of outcome.

It appears that in the groups which we studied, the patients who used the resources of the group the most were the ones who needed the most help. As this was a relatively healthy population, with few schizoid or severely withdrawn and depressed patients, this result might be expected. We were surprised to find, however, that highly active patients did not make greater objective outcome gains than those who were less active.

It may well be that highly active group patients are more *satisfied*.

TABLE 2  
Relation of Patient Activity to Pretherapy Variables

Variable	Number of Times MA
GAS	-.02
CSE	-.23*
SAS	-.18
SEV	.15
UCLA	-.29*
SCL-90	-.29*
SMI	-.25*

NOTE: Scoring of scales such that positive correlation indicates a positive relationship between patient activity and patient functioning. Ns are as follows: GAS—81; CSE—87; SAS—89; SEV—87; UCLA—73; SCL-90—87; SMI—66.

\* $p < .05$

with their treatments than their more unobtrusive counterparts. In a similar manner, therapists believe that more talkative group members are doing better. Therapists and patients may very well share the belief that mere participation in group discussion is an indicator that therapy is beneficial for the person. Nonetheless, not one objective self-report measure nor the ratings of independent clinical interviewers was related to level of member participation. This negative finding probably indicates that when one is hoping to predict objective indices of outcome in time-limited groups with relatively healthy patients, activity level in itself must be viewed as a poor prognosticator. Thus, although we may be able to say that those who are more active are more likely to be satisfied and *feel* that they have benefited, concrete changes such as reduced symptomatology, improved self-esteem, better social functioning, and so on appear unrelated to a member's activity level in the group per se.

Our findings contradict those of some researchers who have previously found positive relationships between verbal activity and patient improvement in psychotherapy (McDaniel, Stiles, and McGaughey, 1981; Sloane et al., 1975). One possible explanation of this discrepancy would be that the measures used in those studies were primarily subjective in nature; this turns out, however, not to be the case. As summarized by Orlinsky and Howard (1986), more positive relationships between verbal activity and outcome have been found using prepost differences than with subjective patient or therapist ratings. Our findings are consistent, however, with the general finding that process-outcome relationships in psychotherapy frequently differ depending on the perspective from which outcome is measured (Orlinsky and Howard, 1986).

A second possibility is that our measure of verbal activity, number of times MA, is substantially different from previous measures of verbal activity, which have largely assessed the number of words spoken by the patient. This possibility cannot be ruled out. It is possible for a patient to speak quite a lot on a consistent basis, without ever becoming the MA; conversely, by our definition the MA need not necessarily be the person who spoke the most in the half-hour segment. The construct of MA is one which is unique to group psychotherapy; it has no analog in the individual therapy context. This distinction points to a third possibility. Verbal activity may be related

to objective measures of outcome in individual, but not group psychotherapy. The variety of styles of verbal participation in group is, if anything, even larger than in individual therapy. We believe, as clinicians and researchers, that outcome in group therapy is unlikely to be related in any simple way to how much one says. Although the apocryphal story about the silent member who leaves the group "cured" is probably unlikely, *what* members say and *how* they say it is certainly as important as how much they speak. Most group therapists have had the experience of a relatively quiet member suddenly making a major breakthrough in the group, and similarly have seen a very verbose member who is frequently the center of attention carry little improvement to his or her life outside the group.

Group psychotherapy is a very complex process. There are few simple truisms. Although it has long been held that activity level and improvement in group treatment are highly related to one another, our data indicate that this assumption should be questioned. Presumably, more concrete improvement relates not only to the fact that one is speaking, but how and what one is saying.

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## Sexual Abuse Intervention: A Support Group For Parents Who Have a Sexually Abused Child

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### ABSTRACT

*A pilot program for parents of sexually abused children is discussed with a focus on intervention at a systems level. The Parent Support group is based on an eclectic approach and the interventions at the therapeutic and educational levels are described. The evolution of the group is addressed based on the group objectives. Each of the thirteen sessions is described to illustrate the various intervention strategies. Suggestions for implementing a similar group are discussed based on the authors' experience utilizing the presented model.*

The increasing awareness of the problem of child sexual abuse has been widely discussed. Many believe that one out of every four female

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