

Cite as: Sánchez Morales, L., Eiroa-Orosa, F. J., Valls Llagostera, C., González Pérez, A., & Alberich, C. (2018). From feelings of imprisonment to group cohesion: A qualitative analysis of group analytic psychotherapy with dual diagnosed patients admitted to an acute inpatient psychiatric unit. *Psychotherapy Research*, 28(3), 433–445. <https://doi.org/10.1080/10503307.2016.1216623>

**From feelings of imprisonment to group cohesion. A qualitative analysis of group analytic psychotherapy with dual diagnosed patients admitted to an acute inpatient psychiatric unit**

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**Acknowledgements**

The authors would like to thank all the clinical staff and patients who were involved in this study.

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**Abstract**

**Objectives:** Group cohesion, the establishment of hope, and the expression of feelings have been said to be the basic ingredients of group psychotherapy. To date, there is few literature describing therapeutic processes in short stay settings such as acute psychiatric wards and with special patient groups such as addictions. Our goal with this study is to describe and analyze group processes in such contexts.

**Methods:** We used a qualitative methodology combining constant comparative methods and hermeneutical triangulation to analyze therapeutic narratives in the context of a group analytic process carried following Foulkes' and Yalom's styles.

**Results:** The results provide a picture of the therapeutic process including the use of norms to strengthen group cohesion facilitating the expression of emotions in early stages of group development.

**Conclusions:** This analysis is intended to be a guide for practitioners implementing group therapy in contexts involving several constraints, such as acute psychiatric wards.

*Key words: Group Psychotherapy, Process Research, Qualitative Research Methods, Substance Abuse, Acute Psychiatric Ward*

## **Introduction**

As human beings, we are gregarious. We are in constant need of others, and therefore, we always live explicitly or implicitly immersed in groups which outline our social boundaries. Groups help us covering psychological and social needs such as getting a sense of belonging, acquiring knowledge, finding safety and establishing a positive social identity. While some *group* definitions stress the importance of its components, their roles, and their shared beliefs, others circulate around the idea of interaction (Forsyth, 2013). This concept could be said to be the central component of the clinical application of groups.

Groups as instruments of psychological intervention, in addition to allowing cost reductions, have been found to be efficacious in experimental trials and effective in multiple clinical settings (Blackmore, Tantam, Parry, & Chambers, 2012; Kösters, Burlingame, Nachtigall, & Strauss, 2006). In relation to the specific effects of therapeutic groups, they allow a deeper-level communication between its members, fostering further social engagement outside the group (Sánchez del Hoyo, Sanz Rodríguez, Baro Santamarta, & Gómez García de la Pedrosa, 2006). In addition, through interpersonal learning (Yalom & Leszcz, 2005), they provide a realistic context and specific references, promoting alliances and therapeutic relationships, allowing self-awareness among group members (González de Chávez, 1999). For these reasons, even not reaching the improvement effect of outpatients undergoing group psychotherapy, therapeutic groups are considered a very useful treatment tool in acute inpatient units (Martín Cabrero & Martínez Rodríguez, 2009).

### **Group therapy with hospitalized patients**

In some populations, such as psychiatric inpatients diagnosed with schizophrenia, it has been observed that group therapy could be more effective than individual psychotherapy (Kanas, 1985).

Other service users with complicated clinical pictures, such as patients with dual diagnoses (psychiatric disorders comorbid with substance use disorders) requiring an integrated therapeutic intervention, also may benefit from group interventions (Gotoh, 2008). Sandahl, Herlitz, Ahlin, & Rönnerberg (1998) found that patients with comorbid substance use receiving group psychotherapy improved to a greater extent than those who rejected treatment or abandoned. In a meta-analysis of group psychotherapy; Burlingame, Fuhrman, and Mosier (2003) found larger effects for groups carried under certain conditions such as homogeneous group composition, outpatients (compared with inpatients) and patients without substance use problems. The literature on group therapy among hospitalized patients with dual diagnoses has been scarce until now. Bradizza (1997) reported an adaptation of Motivational Interviewing combined with Coping Skills Training to group format for dually diagnosed inpatients. An empirical study carried in a similar setting reported success in combining behavioral and self-help formats (Franco, Galanter, Castañeda, & Patterson, 1995).

In comparison with groups carried out in other contexts, inpatient groups tend to remain in earlier stages of development, as patients often are discharged when cohesion is still developing. Therefore, it might be a priority to establish group norms and foster interpersonal relationships in order to take full advantage of few sessions (Ruiz Parra & González Torres, 2005). Relatedly, therapists usually observe that the expressions of feelings increase within group interactions as sessions go on (Sigman & Hassan, 2006). These interactions have been conceptualized as forms of catharsis, allowing patients to express feelings and conflicts within their personal stories (Yalom & Leszcz, 2005).

Regarding the specific ingredients of group therapy, albeit group cohesiveness may be one of the most important determinants of therapeutic outcomes, the term has been judged to be too

vague and its use presents low consensus among different researchers. Therefore, identifying more specific processes may be rather chosen as a research objective (Hornsey, Dwyer, & Oei, 2007). Irvin Yalom (2005) proposed a list of 11 therapeutic factors in group psychotherapy. Among these; establishment of hope, altruism, universality, expression of feelings and group cohesion, might appear as elements to be explored in inpatient settings (MacKenzie, 1987). The establishment of hope is not only the most commonly observed factor (González de Chávez, Gutierrez, Ducaju, & Fraile, 2000), but it is also considered critical in the recovery of patients, and at the same time, a key element for group adherence, a necessary condition for the achievement of further objectives (García-Cabeza, Ducaju, Chapela, & González de Chávez, 2011).

Considering all these elements, and the importance of specific contextual factors in a hospital setting, this study was developed within an acute hospitalization unit. The study was inspired, regarding its processual components, in the therapeutic factors described by Yalom and Leszcz (2005). Using a qualitative methodology to increase our descriptive potential, we intended to explore the therapeutic factors appearing in a context of group psychotherapy carried with dual diagnosed patients in an acute inpatient psychiatric clinic.

## **Method**

### **Participants**

Inpatients admitted to an acute psychiatric unit from November 2012 to February 2013 reporting active consumption of psychoactive substances and comorbid mental disorders were included in this study. Consumption was considered active if patients had consumed at least an illegal drug, and/or had abused alcohol (according to DSM-IV criteria), in the two months prior to admission, thus becoming candidates for inclusion in the *Dual Diagnosis Program Group* at the unit. The final sample consisted of 20 patients.

## **Procedure**

The *Dual Diagnosis Program Group* is developed as a collaboration of the nursing, medical and psychological teams. All were responsible for the detection of patients who had an active consumption of psychoactive substances. The therapeutic team was composed by a consulting clinical psychologist, a nurse, and a clinical psychology resident. Inclusion and exclusion criteria were defined previously by the therapeutic team and assessed at screening using a semi-structured interview conducted by the consulting clinical psychologist. According to the results of this interview, patients who had adequate communication and relationship skills (González de Chávez, 1999), and who reported current illicit substance use were included. In this space, socio-demographic and basic clinical variables were also collected. Selected patients were asked to sign a therapeutic contract, whereby they agreed to follow group norms.

Patients included in the program attended two types of group sessions. On the one hand, the nursing team led weekly psychoeducative groups in which the main objective was to provide information about the use of drugs, relapse prevention, and to clarify how the use of substances interacts with their mental disorder.

Additionally, they attended a weekly psychotherapeutic group (whose narrative's analysis is the purpose of this article) led by a consulting clinical psychologist (the same who performed the baseline interviews), hereinafter referred to as therapist. This was a psychodynamic group with an open orientation because of the constraints of hospitalization. In these one-hour sessions, the main objective was to increase emotional management skills and the expression of emotions providing an understanding of their difficult relationships with others. These groups were always conducted in co-therapy (consulting clinical psychologist, mental health nurse and clinical

psychology resident). After each group session, a post group meeting of 15-20 minutes was carried out by the therapeutic team to discuss the main topics of the session.

The therapeutic school followed was Groupanalysis. Its founder, S. H. Foulkes (1960) believed that the study of the subject should be done thinking of processes where individuals interact within, instead of isolated interactions. He defined the term “group matrix” as network of communications which is not simply interpersonal, but can be described as a transpersonal process. Although he did not explicitly started the study of intersubjectivity, and despite the specific context in which he developed his work, his theoretical influence goes certainly beyond the specific application to therapeutic groups (Nitzgen, 2014).

### **Session records**

In addition to recording and transcribing each session’s therapeutic conversations (also including comments on the sessions’ environment), systematic observational records of each group session were made retrospectively. Each session was assessed independently by the consulting clinical psychologist and clinical psychology resident before the post-group session. Additionally, all sessions were recorded and transcribed.

### **Data analysis**

Descriptive statistics were used for the quantitative analysis of socio-demographic and basic clinical data. IBM’s SPSS.18 software was used for these analyses. Group therapy conversations were transcribed and categorized in parallel by two groups of experts (clinicians involved in the study and independent researchers) using the constant comparative method following Glaser’s grounded theory (Glaser, 1965). This method was used to develop an explanatory theory of the basic social processes studied in the context of these therapeutic sessions (Starks & Brown Trinidad, 2007). The Atlas-TI software assisted the analysis of the text.

Furthermore, we triangulated this methodology using a hermeneutic approach (Rennie, 2000; Wilson & Hutchinson, 1991), addressing the influence of Irvin Yalom's group psychotherapy model (Yalom & Leszcz, 2005) in the labelling of the different categories and subcategories and the interpretation of the categorical analysis at a further narrative level using the systematic observational records elaborated by the consulting clinical psychologist and the clinical psychology resident. The first part of the analysis helped us to understand how the process of group interaction and norm introjection does happen in an inpatient therapeutic context using a categorical system. The second part helped us making sense of and interpreting therapeutic interactions within our psychotherapeutic knowledge allowing us to build a narrative for the discussion of the present paper.

## **Results**

### **Sample description**

The sample was comprised of 20 patients, 35% of them female. The mean age was 35 years. The predominant diagnosis was psychotic disorder (65%) followed by affective (30%) and anxiety disorders (5%). The main active substance of abuse was cannabis (60%) followed by alcohol (30%), and cocaine (10%).

The average evolution of psychiatric disorders among our users was  $11 \pm 9$  years (minimum 0, maximum 23 years). Patients had been consuming for  $13 \pm 11$  years their main substance of abuse (minimum 0, maximum 30 years).

Most patients in the program had been previously admitted to psychiatric wards at least three times (75%). With regard to substance abuse, only 15% had received previous treatment for substance use disorders. After the pre-group interview, 90% of eligible patients were finally



included in the *Dual Diagnosis Program Group*. All patients agreed with compliance and commitment to the group norms by signing the therapeutic contract.

### **Group therapy sessions transcriptions analysis**

The qualitative analysis of group therapy transcriptions was carried until theoretical saturation was reached, yielding 7 categories comprising 20 sub-categories. Table 1 shows the definitions of the categories.

Table 1. *Occurrence and proportion of narrative categories*

		N	%
Group norms	Acceptance of norms	18	2.7
	Explicitation of norms	37	5.5
	Questioning of norm	36	5.3
Dual diagnosis symptoms	Psychological symptoms	31	4.6
	Drugs	25	3.7
Therapy development	Reinforcement	39	5.8
	Change	24	3.6
	Future Plans	14	2.1
Therapy management	Translation	49	7.3
	Redirection	33	4.9
Group	Group	23	3.4
	Caring for space	14	2.1
	Interaction	67	10
Relationship	Expression of feelings	108	16
	Asking for help	13	1.9
	Giving help	23	3.4
	Identification	19	2.8
	Caretaking-support	68	10.1
Anti-group	Proposal	22	3.3
	Justification	10	1.5

The predominant category was “expression of feelings”. This category refers to narratives where emotional content is explicitly expressed. A 16.04% of the categories were composed by such expressions. The next category by length, containing a 10.10% of the total narrative fragments, was "caring for others-support." This category refers to expressions of understanding and emotional support. The third category was "interaction". Relatedly, 9.95% of the narratives consisted of patients interacting with each other. In these situations, messages were transmitted without being processed by the therapist. In other situations, the group therapist encouraged cohesion processes through messages which have been labelled as "translation", which comprises 7.28% of the categories. The fifth category represents a 5.79% of group meaningful narratives, and was named "reinforcement". These messages consisted of enhancements of the qualities of a group member. The latter refers to conversations in the context of promoting group development. In relation to group norms, the category “explicitation of norms” (the sixth in order of appearance, 5.49%) consists of fragments in which the therapist deals with limits and how to interact in the group. A detailed description and examples of each category can be found below.

## **1. Group norms**

Categories grouped under this name have in common to refer in some way to group norms; either as a reminder, breach or discussion about them. This category includes the following subcategories: 1) Acceptance of norms, 2) Explicitation of norms and 3) Questioning of norms.

### *1.1. Acceptance of norms*

Acceptance of norms quotes are explicit or implied narrative acts which reflect the intention of patients to accept the norms of the group. Example: At a time in which the whole group is very active and in which the difficulty of listening to each other had previously been noted, some

patients raise their hands with the intention of waiting to their turn to speak, while a fellow is still talking.

*"The group started one after another to raise their hands in silence with their bodies leaning slightly towards the patient".*

*(Contextual notes of the therapists)*

In this example we can see how patients in a context of breach of group norms (when one member speaks others should listen) they try to recover normality with a gesture to ask for permission to intervene.

### *1.2. Explicitation of norms*

This subcategory is comprised of fragments of narratives coming from patients or the therapist, where the boundaries of the group space are established and interpersonal dynamics are recalled.

Example: After one norm has been questioned by a patient asking if he can go to the toilet, the therapist recalls the relevant norm to the whole group.

*Therapist (in response to the patient's request): "No, if it is not essential. I will take this time to remind you the rules of the group. You are supposed to come to the group having drunk enough (water) and with all your business done. If someone cannot be, and need to leave (the group), it can be done, but it is important to try to respect the rules and, if possible, hold on for an hour..."*

*In this example it can be seen how patients try to break group norms that have been previously specified in both the pre-group interview as well as at the start of the group. These situations usually occur when the group is in its infancy and tends to decline as the group coheres.*

### *1.3. Questioning of norms.*

In these fragments patients explicitly challenge the norms of the group space. Example: A patient is talking in a context in which the chairs are being put in a circle-like shape, as it is done in each session, before starting the group.

*“Why we do not put the armchairs? They are more comfortable.” (It had been explicitly stated several times that those armchairs cannot be used for this end).*

*(Patient 1, male, 20 years old)*

As we can see in this example the patient, despite having been warned, explicitly asks again something, thus breaking the norms.

## **2. Dual diagnosis symptoms.**

These fragments are narratives in which patients refer to psychological symptoms or aspects related to the use of psychoactive substances. This subcategory includes: 1) psychological symptoms and 2) drugs.

### *2.1. Psychological symptoms*

This subcategory is comprised by narrative fragments in which patients talk about the symptoms of their psychiatric illness. Example: In a context in which a patient talks about suffering and psychological symptoms that have led her to be admitted to the hospital:

*- Patient 1: “I have a bipolar disorder. It has several levels, now I have the mixed level and that's why I'm here”.*

*- Patient 2: “it will go away, I was worse than you before and now I'm better...”*

*- Patient 1: “I thought the headphones will drown me ... then they stole my money and I was checking if I had it all the time ... now it happens to me that when I go to the bathroom... well I think I'm gonna die, that all my body will come out over...”.*

*(Patient 1, male, 20 years old. Patient 2, female, 28 years old)*

In this example it is seen how a patient explains another member of the group some of the symptoms he is suffering and that have led him to be admitted in the hospital.

## 2.2. *Drugs*

This category is comprised by fragments in which patients speak about aspects of substance use (positive or negative effects of drug use). Examples:

A patient reports positive effects experienced when consuming cannabis.

- *Patient 4: "Cannabis makes my poetic ornithological skills develop within the current social situation. It helps me to write, paint..."*

- *Patient 3: "Yeah, me too, when I smoke I get to create".*

*(Patient 3, male, 37 years. Patient 4, male, 40 years).*

In this context a patient also speaks about consumption, but this time he expresses a desire for change in relation to the negative aspects associated with consumption (combined subcategories of drugs and also *Change*, see below under the *Therapy development* subheading).

*"I want to stop smoking joints when I leave this place. Now is the first time I have left it (...). Yes, the doctor told me that if I don't consume, I would be more awake and not so slow".*

*(Patient 5, male, 38 years)*

In both examples interventions in which group members talk about substance use are reflected.

## 3. **Therapy development**

This category gather events in which the therapist or the patients talk about positive aspects of the treatment. Includes: 1) Reinforcement, 2) Change and 3) Plans for the future.

3.1. *Reinforcement.* These fragments include conversations in which patient and therapist comment positive aspects of a group member.

While the group is talking about the admission of an individual, a patient says he wants to stop consuming substances, the therapist reinforces: *"Congratulations JM! Is the first time you try it since you consume cannabis ..."*.

This example shows how the therapist reinforces a member of the group that has been able to fulfill one of his personal goals.

### 3.2. *Change*

This subcategory consists of passages in which patients express the desire to do different things after discharge or even while staying at the unit (related with mental illness, social relationships, activities, etc.). A representative fragment of this category would be:

In a context where the group members are talking about their expectations after discharge, a patient says he has noticed some changes.

*"I have realized that I am calmer, I have more control and do not talk so much"*.

*(Patient 3, male, 37 years).*

With this intervention a group member wants to share with his peers the changes made with regard to his mental health state.

### 3.3. *Future plans*

In these quotations patients express wishes or plans to be carried after discharge. Example: In a context where group members talk about an incident occurred in the psychiatric unit where one member was involved he comments:

*"I have to learn to control my impulses (...) because I get upset for things and then I cannot control myself. I want to learn this and see if they get to show me the day hospital. Tomorrow I have an interview"*

*(Patient 4, male, 40 years)*

In this example it can be seen how a member of the group shares with the rest in order to show the improvements achieved during hospitalization.

### **Therapy management**

This category consist of fragments in which the therapist redirects the group or accompanies its advancement. Includes: 1) Translation, 2) Renewal.

#### **3.4. Translation:**

This subcategory includes moments in which the therapist interprets the words and feelings of a group member so as they are understood by the rest. Example: In a context in which a group member would like to apologize to a colleague, but the latter is not aware of it as the former said it superficially.

*Therapist: It seems that [Patient's 8 name] would like to apologize again.*

*In this fragment it is observed how the therapist clarifies the intervention of a member to the rest as the message was not being understood.*

#### **3.5. Redirection:**

This subcategory addresses therapeutic spaces in which the therapist tries to resolve a confusion or help focusing the group on therapeutic work. Example: In a context in which group members speak all at once, producing an incomprehensible dialogue:

*Therapist: I don't know the rest, but for me it is difficult to follow the conversation. Maybe we should try to talk without overlaps, so we can find out about what you are talking about.*

In this example the therapist redirects a situation in which all members of the group were interacting improperly toward a therapeutic space in which there is the possibility for better communication.

#### **4. Group.**

This category collects moments in which therapist and/or patients make explicit reference to the group with the aim of preserving or caring for it. Includes: 1) Group, 2) Caring for space and 3) Interaction.

##### *4.1. Group*

This subcategory refers to situations in which patients and therapist talk about the dynamics of the group, or aspects that might affect group dynamics.

Example: In a context where group members talk about conflicts between patients:

*“(...) yeah, it is difficult here hospitalized, because of the way we are. One day you are fine, but the next you are turned upside down, and then the next we are well and perfect.*

*(Patient 3, male, 37 years).*

In this example a patient talks about how the changing symptoms can affect the dynamics of the group.

##### *4.2. Caring for space*

We grouped under this subcategory situations in which patients or therapists make reference to the preparation and care of the group space, thereby facilitating group cohesion. Example: At the start of one of the groups when therapists arrive, two group members prepare the space to get ready.

*Patient 3 comes into the room and places the chairs around the group.*

*Patient 1 enters the room and begins to set up the chairs.*

*(Patient 1, male, 20 years. Patient 3, male, 37 years).*

This example shows how patients develop self-care space initiatives within the group, implying that it has somehow already established a sense of group and therefore a feeling of cohesion among its members.



### 4.3. *Interaction*

In this category is comprised by direct communications (one by one) between group members.

Example: In one of the group sessions, reference is made to the care of its members:

*Patient 2: [Patient's 5 name] you're tired*

*Patient 5: Yes, I'm very tired*

*Patient 2: [Patient's 5 name] you do not speak as if you were in the group*

*Patient 5: I'm just learning*

*(Patient 2, female, 28 years old. Patient 5, male, 38 years).*

*In this example we can see how a typical direct interaction between two members of the group takes place.*

## **5. Relationship**

These interactions include conversations in which patients or therapist take care of themselves and/or the rest of group members. Includes: 1) Expression of feelings, 2) Asking for help, 3) Giving help, 4) Identification and 5) Care for others-support.

### 5.1. *Expression of feelings*

This subcategory groups situations in which patients verbalize emotional content. Example:

*Patient 3: I feel caged and cannot get out. I feel claustrophobia.*

*(Patient 3, male, 37 years).*

Through this intervention a patient shares with the rest how he feels.

### 5.2. *Caretaking-support*

In this subcategory we have clustered conversations about emotional support and understanding of the emotions expressed by another group member.

Example: In a context where a group member explained the emotional distress that generated their current situation:

*Patient 3 looks at Patient 7, she takes his hand, and they caress each other's hand.*

*Patient 3: Thank you very much.*

*Patient 3 leans towards patient 7, and they pick their hands harder.*

*(Patient 3, male, 37 years. Patient 7, female, 48 years).*

This example shows how a group member supports a colleague holding his hand after explaining how stressed he was.

### **5.3. Giving help**

We have included in this subcategory situations in which a patient or the therapist help a member of the group to solve a situation or confusion. Example: In a context in which a group member explains a situation that generates him high levels of anxiety.

*Patient 15: And what happened to you, might not be an anxiety attack?*

Therapist: Look what *[Patient's 15 name]* says

*Patient 15: Yeah, I guess, but I do not know or do not remember how I got here ...*

*(Patient 15, female, 53 years)*

*In this conversation we can see how a group member intends to help solving the problem of a colleague through questions that might clarify the stressful situation.*

### **5.4. Asking for help:**

In these narratives a patient expresses implicitly or explicitly a need to resolve confusions or doubts. Example:

*Patient 2: What day is it today? I do not know when it's lunch, or dinner, I'm disoriented, and I don't know the day.*

*Patient 1: Me neither. Is it 17?*

In this example we can see how a group member implicitly asks for help as he realizes he does not know certain information that he should know.

### **5.5. Identification**

We coded quotations with this label when we interpreted that a patient or the therapist was empathizing with feelings expressed by group members. Example: A group member explains misbehaviors with his former partner.

*Patient 3: I know, it happened to me with my ex-. We were together for a while, and I behaved badly.*

*Patient 7: Yes, my husband also throws things when he's angry.*

*Patient 4: (laughs) I have also done this... you' start throwing things, but then ...*

*(Patient 3, male, 37 years. Patient 4, male, 40 years. Patient 7, female, 48 years).*

*In this example, two members of the group feel identified with the problems explained by a peer and share with him their experiences.*

## **6. Anti-group.**

The anti-group category includes quotations in which patients avoid psychotherapeutic work. Includes: 1) Proposal and 2) Justification.

### 6.1. *Proposal*

We have grouped under this name proposals of patients which are far apart from the established objectives of the group.

*"We could do a theatre act, a drama to distract ourselves."*

*(Patient 2, female, 28 years old)*

This example shows how a group member proposes objectives which are not feasible within the group.

### 6.2. *Justification*

These quotations include quotations in which patients give an explanation about why they do not follow group norms or why they move away from its objectives. Examples:

After a patient asking whether he can go to the bathroom, the therapist remembers the rules of the group and another patient replies:

*"Patient 5: I didn't know the rules"*

*(Patient 5, male, 38 years).*

In a context where one of the patients, clearly drowsy, is wondering what time it is, and after the therapist had reminded the group its norms and duration:

*"With medication we are very sleepy. I try to open my eyes, but I can't".*

*(Patient 16, male, 46 years).*

In both examples the therapist should remind the group norms as the proposals represent an infringement, and in both cases the patients justify their transgression.

## **Group evolution**

Table 2 shows the evolution of the sessions. The seven sessions are divided into two separate periods due to the Christmas holidays. The first period includes session one to five, the second period includes the sixth and seventh sessions.

In the early sessions (first two) the group atmosphere has still a low level of cohesion. It can be understood as a process of encounter; patients participate individually with little regard to what other patients are saying. This can be seen especially in the first session. In the second session group members begin to question the norm, which makes sense before accepting it as their own. In both sessions we can see an active involvement of the therapist. In the first session her involvement can be noted in terms of group norms, while in the second, mostly regarding the need to promote identification and therefore, group cohesion.

In the third session the group shows cohesiveness. Categories such as expression of feelings and interaction have increased, while categories referring to an active role of the therapist decrease. The group continues to grow in cohesion in the fourth and fifth sessions. The fifth session comes to a point where the group functions autonomously and categories related with an active role of the therapist do not appear. From the third to the fifth session, categories of expression of feelings and interaction remain high. In the fourth session, explicit identifications between group members and verbalizations change. At the same time, problematic behaviors in relation to group members appear.

After the Christmas break, groups are restarted. The group maintains part of the dynamics, but the therapist needs to do some translations to include new members and re-establish the cohesion climate. At the sixth session we can see how themes common to the first session appear, especially with reference to symptoms. Again, it is an encounter group, where the therapist needs

to have an active role in promoting group cohesion and defining its functions. However, the group does not start from the beginning as in session one, we can see a clearly more cohesive climate, participants just need a little help in form of translations to start expressing their feelings again. The seventh session is less intense. Discussions about norms and translations, share space with support and expression of feelings.

Table 2. Detailed account of each session's therapists' blinded assessment combined with most widely used categories.

Session	N° of patients	Assessment of general environment and issues		Assessment of patients' participation		Relational patterns in the session	Frequencies of most widely used categories (n=6 or more in each session)
		Therapist A	Therapist B	Therapist A	Therapist B		
1	3	<p><b>Environment:</b> Assertive, need to create another reality.</p> <p><b>Issues:</b> 1) Need to create another reality as opposed to jail. 2) Topics related to mental illness. 3) Drugs and medication.</p>	<p><b>Environment:</b> Participative, demanding, and vindictive.</p> <p><b>Issues:</b> 1) Disorientation-orientation. 2) Desire to change things in the psychiatric ward. 3) Disease and drug use.</p>	<p>1) Participative, helps peers.</p> <p>2) Participative, tendency to create another reality.</p> <p>3) Non participative. Anger, rage.</p>	<p>1) Very participative, tries to help the group.</p> <p>2) Very participative, idealist, with desires of changing the station.</p> <p>3) Expresses rage but controlled. Feels caged, does not have to be here.</p>	<p>All patients with therapist.</p> <p>Dyadic relations between 1 and 3.</p> <p>Patient 2 relation with the rest of the group.</p>	<p>1/2) Proposal (11) / Explication of norms (11).</p> <p>3) Caretaking-support (8).</p> <p>4/5) Reinforcement (7) / Redirection (7).</p>
2	5	<p><b>Environment:</b> Confusion</p> <p><b>Issues:</b> Getting organized to respect turns. Need tell each his own story. Peer support.</p>	<p><b>Environment:</b> Cohesion, chaos.</p> <p><b>Issues:</b> Death wish and fear of death. Group norms.</p> <p>Desire to share and express affection for the group.</p>	<p>1) Participative. Seeks constantly the therapist. Cares about one of the group members.</p> <p>2) Tries to organise speaking turns. Difficulty in complying with speaking turns. Takes care that everyone gets involved. Invites new participants to talk.</p> <p>3) Participates, seems happy and tries to respect speaking turns.</p> <p>4) Participates and gets exposed explaining his personal situation. Explains in detail psychiatric symptomatology.</p> <p>5) Contributes very little. Minimises drug use.</p>	<p>1) Very involved, tries to help the group members. Express verbally his affection towards them.</p> <p>2) Tries to lead the group. Takes the themes towards himself. Also expresses affection for the group and tries to accommodate everyone.</p> <p>3) Participates and promotes group cohesion.</p> <p>4) Tries to be the centre of attention of the group and that the group wants to protect him. Capable of self-regulating himself in conversations. Tendency to victimhood. Shows affection for another patient.</p> <p>5) Comments loosely connected with the rest. Tries to join the group his own way.</p>	<p>Patients 1 and 5 with therapist.</p> <p>Dyadic relations between 1,2,3 &amp; 4.</p>	<p>1) Expression of feelings (16)</p> <p>2) Caretaking-support (15)</p> <p>3) Interaction (13)</p> <p>4) Questioning of norms (12)</p> <p>5/6) Redirection (11) / Explication of norms (11)</p> <p>7) Translation (10)</p> <p>8) Group (9)</p> <p>9) Questioning of norms (8)</p>
3	7	<p><b>Environment:</b> Warm, cohesion.</p> <p><b>Issues:</b> Need to belong to groups, cohesion. Saying thanks in aid processes.</p>	<p><b>Environment:</b> Expression of feelings.</p> <p><b>Issues:</b> Relationship with peers</p>	<p>2) Encourages participation. Calm.</p> <p>3) Participates even though he finds difficult to get included.</p> <p>4) Expression of feelings.</p> <p>5) Remains aloof, participates little.</p>	<p>2) Peaceful and stable. Respect the right to speak. Assumes a group caregiver role.</p> <p>3) Comments outside the conversation and interruptions. However, more capable of self-regulating.</p>	<p>All patients but 2 and 5 with therapist.</p> <p>Dyadic relations between 1,3,4 &amp; 7.</p>	<p>1) Expression of feelings (24)</p> <p>2) Interaction (17)</p> <p>3) Translation (8)</p>

Session	N° of patients	Assessment of general environment and issues		Assessment of patients' participation	Relational patterns in the session	Frequencies of most widely used categories (n=6 or more in each session)	
				6) Participates and gets included. It appears as independent though he is and feels within a group. 7) Included in the beginning and then, when emotional issues are touched she participates to a lesser extent. 8) Participative. Involved in the need to belong to a group.	4) Quiet, less need to feel the centre of the group, less dramatic. 5) Physically present but absent from the group. Difficulty to suit the group and integrate. 6) Rivalry and conflict with some members of the group but is capable of self-regulating. 7) Sometimes well adapted and participative, while sometimes more drowsy and absent. 8) Participate actively seeks approval of the therapist. Exposes his emotions in third person.		4) Reinforcement (6).
4	5	<b>Environment:</b> Cohesion <b>Issues:</b> Loss of partner. Uncontrolled impulses. Guilt associated with loss and attempts to repair. Changes during the therapeutic process	<b>Environment:</b> Emotion, expression. <b>Issues:</b> (Desire of) Changes. Impulse control. Loss of affective relations.	3) Sad because loss of partner. Lack of impulse control generates guilt. 4) Aids patients. Points out the positive side of the relationship trying to minimize guilt. 7) Tries to stay awake and participate. Provides information about her relationship. 9) Involved from the beginning but when patient 1 asks to go, he also asks for it arguing he did not feel good. 10) Difficulties in inclusion. Contributes just to say that he does not want to be. Ambivalent.	3) Thrilled, guilt. Sadness. Greater self-control, desire for change. 4) Desire for change impulse control. Spotlight. 7) Very sleepy, tries to listen, but has trouble staying awake. 9) Initiates interaction but leaves the group with his partner (imitative behaviour, difficulties staying) 10) Rejects the group, confrontational. Leaves the group.	All patients with therapist. Dyadic relations between patients 4 & 5 and these two patients with the whole group.	1) Expression of feelings (16) 2) Interaction (12) 3) Change (10) 4) Identification (9) 5/6) Translation (8) / Questioning of norms (8). 6/7) Caretaking-support (7) / Future plans (7). 8) Explication of norms (6)
5	2	<b>Environment:</b> cohesion warmth <b>Issues:</b> Christmas, gatherings	<b>Environment:</b> Encounter, communication, affection, emotion <b>Issues:</b> Christmas, loved ones	3) Expressive, excited. Difficulty in the relationship with his brother. 7) Participates more than usual. Expression of feelings. Interest in the other.	3) Participatory and communicative. Emotional and affective. 7) Very communicative, able to confront and pick up at the same time. Caregiver.	All patients with therapist. Dyadic relation between the two patients.	1) Expression of feelings (16) 2) Interaction (10) 3) Reinforcement (7).



Sessio n	N° of patient s	Assessment of general environment and issues		Assessment of patients' participation		Relational patterns in the session	Frequencies of most widely used categories (n=6 or more in each session)
6	6	<b>Environment:</b> Cohesion <b>Issues:</b> Doubts about the future. Symptoms. Side effects. Importance of company	<b>Environment:</b> Cohesion <b>Issues:</b> Desire for change. Feelings of tightness income. Soledad, company, family.	11) Included although has trouble with it. Concrete. Alone. 12) Included, but little involved. Talks about symptomatology. Listens actively. 13) Active listening and empathy, accompanying. 14) Difficulty respecting speaking turns. Actively involved. Not listening, self-cantered. 15) Included and involved, reinforces others. 16) Participates and explains symptoms. Provides support to other group members.	11) Participate and try to integrate, has trouble though. Brief and specific interventions. 12) Integrates later without problems. Good listening attitude. 13) Participative and focused on reality. Provides assistance to the group. 14) Labile. Difficult to hear and connect with the rest of the group but receives help from this. 15) Participatory. Provides advice and new perspectives to the group. 16) Desire for change. Empathetic. Feelings of guilt about the past.	All patients with therapist. Dyadic relation between 3 and 5.	1) Expression of feelings (27) 2) Caretaking-support (14) 3) Reinforcement (13) 4) Translation (12) 5/6) Giving help (11) / Interaction (11) 7) Change (8)
7	6	<b>Environment:</b> Trustworthiness <b>Issues:</b> Norms, symptoms, protection, labels and stigmatization	<b>Environment:</b> Security. <b>Issues:</b> Diagnostic labels. Norms.	11) Participates little and when she does is loosely connected to the group. 15) Participates, mindful of peers providing support. 17) Connected but cautious communicating. It is easier for her to provide information than talk about herself. 18) Participates, difficulties slowing down, and respect the right to speak off others. 19) Included, active listening. 20) Active listening but little participation. Identifies with some symptoms.	11) Difficulty integrating into the group theme, although somewhat more connected and less sleepy. 15) Well integrated in the group. Liked by her peers who see it as strong. Has difficulties expressing affection for the group but eventually gives back something. 17) Provides answers to the group, but has difficulties talking about herself, sometimes isolated. 18) Difficulties self-regulating. Need to stop him. 19) Integrated in the group, tries to accompany the rest of the group. Looks after that no one is left alone. 20) Integrated. Somewhat suspicious, but manages to trust the group despite being somewhat interpretive.	All patients with therapist. Dyadic relation between 2 and 3.	1/2) Caretaking-support (7) / Acceptance of norms (7) 3/4) Expression of feelings (6) / Translation (6)

## Discussion

The major methodological advance of this study was the combination of an adapted grounded theory method of patients' narratives (table 1) with a hermeneutic analysis of the perspectives of others in the hospital system (table 2). This has allowed us to contextualize and give meaning to the categories and subcategories not only chronologically, but also in a functional manner, understanding how norms help promoting the autonomy and expressivity of group members.

The treatment of patients with severe mental illness and substance use problems usually involves a more difficult psychotherapeutic management process, requiring integrated interventions. The usefulness of therapeutic groups for the treatment of these patients in hospital contexts has been already described (Gotoh, 2008). Although it is not considered to be standard clinical practice, group psychotherapy has been shown to be effective in severe patients admitted to psychiatric wards (Kanas, 1985; Martín Cabrero & Martínez Rodríguez, 2009). Given the profile of hospitalized patients and the need for a comprehensive and effective care, this type of treatment, usually accompanied by psychoeducational interventions, is frequent in such contexts.

Consistently with the theoretical approach of this study, the most common therapeutic factors for dually diagnosed inpatients were: *expression of feelings, caretaking-support, interaction, translation and explicitation of norms*. Increased expression of emotions and interaction, as well as decreasing references to group norms could be interpreted as a sign of increased group cohesion, one of the main therapeutic factors described by Yalom and whose exploration was the main objective of this study. In this way we have shown how group dynamics keep progressing until group cohesion facilitates the reduction of therapist's interventions and increases the ability of patients to think and act autonomously.

As already pointed out by previous authors conducting studies in similar settings (MacKenzie, 1987), our study shows the importance of creating a space for inpatient group interaction, where they are able to express emotional content as well as give and receive peer support. These results suggest the importance of group support and emotional expression in hospitalized patients. Both factors are described in previous literature as important group therapeutic elements (Lara et al., 2004). Yalom & Leszcz (2005) refer to these factors when they describe their therapeutic factors. Group support and emotional expression may be matched to factors such as altruism and catharsis according to the conceptualization of these authors.

Our results represent a practical evidence of the role of therapeutic groups in a psychiatric inpatient ward. A space where participants can express their feelings, leaving the passive role of help receiver, allowing themselves to be the protagonists of the event of help, caring for others and participating in a socializing experience through social interactions. Through translations and redirections, the entire process is supervised by the therapist, who encourages participants to see their peers as members of a group that is governed by specific norms. This process creates a safe space where they can just “be”. The continued presence of expressions of feelings may suggest a reflection on the need for a space where inpatients can give voice to emotional contents, which are often silenced in these hospitalization contexts.

Therapeutic groups improve patients' communication and relationship skills (Sánchez del Hoyo et al., 2006); two capacities often hampered by the context of hospitalization, confirming the importance of creating communication and therapeutic spaces during the psychotherapeutic process. This connects with the importance of early and comprehensive psychotherapeutic treatment (Berner et al., 2008), as group treatment in the context of hospitalization is in our case.

As we could see in table 2, regarding early sessions' group evolution, it seemed to be in need of norms. Norms provide a safe context in which group members are able to start expressing feelings. The groups as an entity needs to establish how their participants might relate to each other in this new space and thus, a more active approach of the therapist is needed. Initial sessions are dominated by categories related to therapy management (redirection and translation). Redirection refers to group boundaries and norms. Translation refers to interventions where the therapist tries to encourage group members to identify themselves with each other. Both are important conditions to create group cohesion, as cathartic expression and self-revelations are difficult to perform in early group stages (Argyrakouli & Zafiropoulou, 2007). These categories, dominant at the beginning of the process of group cohesion, become minority when group cohesion increases. However, interpersonal learning, altruism, universality, instillation of hope and imitative behaviors (in the form of expression of feelings, expressions of support, interaction and group discussion), some of Yalom's primary therapeutic factors (Yalom & Leszcz, 2005), appear early in the second session. Accordingly, categories such as the appearance of expressions of feelings and interactions increase exponentially in the next sessions. These interactions increase as group members identify themselves as peers and become more cohesive, more able to self-manage and self-regulate, while the role of the therapist becomes less active. This group environment favors the emergence of catharsis as an expression of different emotions, contributing in turn to increased group cohesion (Yalom & Leszcz, 2005). Table 2 might be understood as a way of putting together the basic themes of each session and understanding group dynamics in context. It can be understood as an intermediate step between the merely descriptive (Table 1) and our interpretative efforts.

We should also acknowledge the limitations derived from the methodology and context where this qualitative study has been implemented. The high turnover of patients, the difficulties in transcribing the sessions, or the medical conditions in which participants are, may create barriers when deepening into these therapeutic processes. We also used a very specific type of patients, i.e. inpatients admitted to an acute psychiatric ward diagnosed with dual disorders. However, the homogeneity of group members in regard to substance use (at least one consumption two months prior to admission) was decided in order to facilitate identification and cohesion within the group. In this regards, previous literature indicates that homogeneity may increase the positive effects of the group therapy experience (Burlingame et al., 2003).

The results of this qualitative study underscore the need to include therapeutic group spaces in psychiatric wards where patients may be able to develop relational and communication skills, which may be important tools in their recovery and reintegration in their communities.

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