Group Therapy in Family Medicine Part 3: Starting the Group

William H. Friedman, PhD, Eric Jelly, MD, and Pamela Jelly, SRN
Chapel Hill, North Carolina

This paper is the third in a four-part series and in it some issues and techniques pertaining to the pregroup screening interview are discussed as well as the initial meeting of a therapy group in a family practice setting. The screening interview enables patient and group therapists to decide whether or not the patient might benefit from group therapy. Topics covered in such an interview are discussed. Some ways of beginning and of ending the first session are described.

It has been suggested in previous papers[1,2] that group therapy may provide the family physician with a potent alternative prescription. A therapy group in family medicine enables the physician to respond to patients' needs for relief from emotional as well as physical stress. Referral to a mental health professional becomes less necessary except in instances of major mental illness. It has been shown that the establishment of a therapy group in the context of a family practice is feasible, and some clinical evidence of its effectiveness has been presented. The present paper discusses some issues and techniques pertaining to the pregroup screening interview and to the initial meeting of a therapy group in this setting.

Indications for referral have been discussed elsewhere[2] and are summarized briefly here. *Patient characteristics* which suggest the possibility of referral include: (a) a strong emotional component or concomitant of physical complaints; (b) poor response of physical complaints to medical treatment; (c) frequent visits to the physician at the office; and (d) frequent afterhours calls. *Physician responses to patients* which suggest the possibility of referral include feelings of frustration, hopelessness, and sadness about the relationship. Thus, both patient and physician may feel they are at an impasse. Recognition of this feeling may be difficult; however, once identified, referral for group therapy may be indicated.

The Screening Interview

The main function of the screening interview is to enable the patient and the group therapists to decide whether or not the patient might benefit from group therapy. Screening interviews are necessary because the group therapists are in a better position than the referring physician to assess the patient's suitability for their particular group.

Two contracts with the patient are negotiated during the screening interview. The first is related to what will happen during the screening interview itself. Generally that involves agreeing to decide

From the Department of Family Medicine, School of Medicine, University of North Carolina, Chapel Hill, North Carolina. Requests for reprints should be addressed to Dr. Eric Jelly, Department of Family Medicine, Room 738, Clinical Sciences Building 229 H, The University of North Carolina-CH, Chapel Hill, NC 27514.

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whether or not the patient should join the group. The second contract pertains to what will be done in the group and constitutes a commitment by patient and therapists to work together in a therapy group.

Sometimes, at the conclusion of the screening interview, patient and therapists may agree not to work together. In such cases, the patient should be referred back to his/her physician and the group therapists should discuss with the physician why they did not agree to treat this patient in their group.

Conduct of the Screening Interview

Both co-therapists should be present at the screening interview. It will usually be helpful if there is some discussion beforehand about how the interview is to be conducted, and which of the co-therapists will be responsible for eliciting and providing various items of information.

At the beginning of the interview, the co-therapists should tell the patient what they already know about him, ie, what they learned from the referral source. Then the patient should be asked what he already knows about group and about the reason for referral. This helps to avoid repetition, thus contributing to the efficiency of the interviewing process.

It is important, next, to find out what the patient expects, and also what he might fear, from the group experience. Some patients will not know what they want. In that case, the therapist's function is to provide information, and to help the patient focus his/her wants realistically. For example, a frequent expectation is that the other group members and the group therapists will offer advice to the patient; and he may feel that advice is all he needs in order to be able to resolve the problems for which he was referred. The patient may, of course, have quite realistic expectations of the group, in which case the therapist's function is to reinforce them.

Patients come to the screening interview with many fears. The most common fear is that they will be required to tell their most intimate secrets to strangers who will then laugh at them or dislike them. Other common fears include that of being a bore, of taking up too much of the group's time, or of getting insufficient time for oneself. If these fears are not mentioned spontaneously by the patient during the screening interview, the therapists should gently elicit them.

The co-leaders are engaged, during the screening interview, in a diagnostic process to assess the magnitude of the patient's disturbance, the readiness of the patient to respond to group therapy, and the suitability of the group for the patient. In this process, they assess the ability of the patient to make those commitments which are necessary in order for the group to function effectively and therapeutically. These commitments include arriving at the appointed hour, maintaining confidentiality, paying for the sessions, and not arriving under the influence of alcohol or some other drug. The group leaders, in turn, agree to make their expertise available to the patient and to the group.

Attrition

There are three points at which attrition occurs. The first is between referral and the screening interview. Not every patient accepts referral for the screening interview. Some take the group therapists' names and telephone numbers, but never make the appointment. Others (usually a small number, fortunately) make the appointment but fail to appear.

The second attrition point is between the screening interview and the first group session. Some patients are invited to the group, accept the invitation, and then fail to appear for the group meeting. The longer the interval between the screening interview and the first group session, the greater the attrition.

The third attrition point is after the group has started. It is not unusual for patients to withdraw after one, two, or three sessions. Indeed, it is more unusual for everyone to stay.

In the therapy group described in previous papers,[1,2] 12 referrals were made. Nine patients attended the screening interviews, six of these attended the first session of group, and one of these dropped out after the third group meeting.

Typical of the patients who dropped out at the first attrition point was the woman who called for an appointment for screening, declaring that she had no problems and no idea of why she had been

referred to the group. It proved impossible to find a mutually agreeable time to hold the screening interview. Another patient refused to come to the screening interview unless the therapists guaranteed her boyfriend admission to the group itself—a condition the therapists found unacceptable. This patient and her boyfriend might have been considered for couples' group therapy. Couples should not be admitted to groups of individuals.[3]

The patients who were not invited to group or did not agree to come are exemplified by one who did not yet feel ready to respond to group therapy and another for whom confidentiality seemed an insurmountable problem.

The patient who dropped out after the third group meeting at first appeared deeply committed to the group. Indeed, she engaged in considerable self-disclosure during the third session. However, in retrospect, it became evident that this self-disclosure was premature. She also differed from the other group members in education, socioeconomic level, and articulateness. These differences made it difficult for her to accept the support of the group following her self-disclosure, and she withdrew, though retaining contact with the therapists and with the referring physician.

It is not unusual for attrition to reach 50 percent of referrals, as this experience exemplifies. It is somewhat atypical in that, once the group began, the attrition was lower than the rate which might have been anticipated.

Starting the First Session

At the beginning of the first session, certain items of business should be transacted. Most group therapists have some guidelines or rules which they ask the patients to follow. While these guidelines may have been discussed during the screening interview, it will generally be helpful to review them briefly at the opening of the group. The number of rules or guidelines there are, or should be, will depend largely on the preferences of the group therapists themselves. There is no standard or customary list of guidelines. One therapist, for example, has $2\frac{1}{2}$ pages of rules which he distributes to the patients during the first session of the group; another therapist has three brief guidelines which he offers verbally. It is suggested here that there are four issues which should be discussed at the first session: (a) Group members should be told that they are free to repeat outside the group what they themselves have said, and what the therapists have said to them; but that they should keep any other discussions confidential. (b) Members should be told that they will not be required to disclose intimate secrets to the group. While this will have been discussed in the screening interview, it bears repeating now and perhaps at intervals during the course of therapy. However, patients should understand that while intimate self-disclosure is not required, neither is it discouraged. (c) Members should be asked to report to the group if they have any significant contacts with other members in the interval between group sessions. (d) Unless the group leaders feel strongly about it one way or the other, the members should decide whether or not smoking will be permitted during the group sessions. Careful attention to this discussion by the therapists will provide clues as to how these patients are likely to interact once the work of the group has begun.

After these matters have been attended to, the work of the session may begin. A good method for getting things underway is to initiate a survey: an initial invitation by the therapists to the patients to engage in interaction. What is surveyed is less important than the fact that the survey takes place. The purpose of the survey is to provide some structure and safety for the participants: the more information that people have about other group members, the more comfortable they will become. The group leaders might initiate the survey with such questions as, "What are your expectations about attending this group?" "What is the most pressing problem that you recognize at this moment?" Or, more simply, "Introduce and describe yourself." A somewhat different approach to the survey is to invite each member to introspect about the feelings and sensations which are impinging upon them at the moment, and then to report on these feelings to the group.

The survey serves a dual purpose—allaying the anxiety of patients and initiating interactions, while providing the group leaders with information about how this particular assemblage of people fit together in a group.

It is difficult to predict what might take place after the completion of the survey. The task of the group leaders is to continue to allay patient anxiety, initiate self-exploration, and facilitate interaction related to the process of change. Learning how to do these tasks comes principally from experience and supervision.

Ending the First Session

Toward the end of the first session, movement toward closure should be made. For example, the group leader might indicate that the first session has been an ice breaking time, with the interactions being stiff and somewhat awkward. He/she might observe that in future sessions, the ice breaking will come earlier and more easily. He might then offer a brief summary of what has transpired. Finally, it is important for the leaders to give an opportunity for questions to be asked before formally ending the session. Efforts by the group to extend the time should be resisted, and a firm policy of starting and finishing on time should be followed.

When the session has formally ended, it is important for the therapists to stand up, though not necessarily to stride immediately from the room. Rising offers a behavioral as well as a verbal signal that the session has ended. However, it is important to realize that in many ways the group process continues until the last member leaves the room.

Caveats

The authors would add two notes of caution. The first is that these papers are intended to familiarize the physician, in some detail, with what happens in group therapy; however, the series does not constitute a how-to-do-it manual, and perusal of these papers does not confer upon the family physician competence to conduct such a group. It is hoped that these papers will clarify what happens in the process of building a therapy group, and will show that the learning required to develop competence is not too time consuming for the busy physician. The purpose of these papers is to stimulate; competent supervision provides support, guidance, and sanction.

The second note of caution is addressed to those who feel that because they *can* do something, they *ought* to do it. Such people, and we fear that there are many family physicians among them, carry a heavy burden of responsibility which is no lighter for having been self-inflicted. The potential for the development of any new skill may be regarded as adding to that burden. It is *not* suggested that the development of new skills in group therapy is what any conscientious family physician ought to do; rather, it is suggested that, for those with both interest and talent in the psychotherapies, it is possible to legitimately pursue competence in group psychotherapy in the context of a family medicine setting.

Concluding Comment

The issues confronting the group leaders at the beginning of the second and subsequent sessions are somewhat different from those described in this paper because of the continuity of the group. In the next and last paper in this four-part series, a case report of a patient's progress through the group will identify some of the methodologies and philosophies of group therapy in family medicine.

References

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