Psychotherapy Guidebook

Multidisciplinary Group Therapy

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Table of Contents

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DEFINITION

Multidisciplinary Group Therapy is a group therapy for acutely distressed "revolving-door" patients, conducted by a team of multidisciplinary facilitators under the guidance of a staff therapist. The multidisciplinary group was devised to meet the problem of revolving door, in-hospital patients. The objective is to maximize stimulation, interest, and rapport by providing a wide variety of roles, models, and experiences with which patients might be induced to identify and interact.

HISTORY

Multidisciplinary Group Therapy is an amalgam of crisis intervention group work, multi-therapist intervention, and interdisciplinary treatment team concepts. Emphasis on brief hospitalization has brought with it the phenomenon of the revolving-door patient, which presents a human tragedy demoralizing patients and staff. The typical revolving-door patient is a chronic psychotic who repeatedly returns to the hospital in a severe state of personality fragmentation. These patients have responded to repeated

experiences of interpersonal upheaval and lack of success in community living with apathy, hallucinations, and overwhelming feelings of helplessness. Some patients are so frustrated by repeated experiences of failure that they are on the verge of exploding into some form of violent action.

TECHNIQUE

The group contains patients of both sexes. Age and sex differences in the patient group have their equivalents in the therapist group, helping to mediate generation gap and life-style differences. As patients and facilitators compare viewpoints and life experiences, there is opportunity for reality affirmation and correction of distortions. The facilitators primarily apply crisis-oriented problem-solving techniques. They try to get the patients to recapture the sequence of events that led to hospitalization, and get them to come to grips with what they are saying and doing and its influence on others. With help the patients are frequently able to reconstruct the behavior that culminated in their current hospitalization, and even gain some awareness of the roles they played in their predicament. A basic assumption is that for patients to recognize the relationship between their bizarre acts, between the neglect of their children, their household and themselves, and hospitalization, is an important step in breaking the cycle of rehospitalization. The multidisciplinary group also tries to have the patients gain awareness of their maladaptive attitudes and feelings, how these affected themselves and their

relationships, and how they earned rejection. The major emphasis is on helping the patients to become more adaptive and to recognize the possibility and desirability of alternative and more effective problem solutions.

During the sessions, seating is arranged so that a member of the facilitator group is seated between every two patients. The interspersing of patients and facilitators makes it possible for the nearby facilitator to easily reach out to a highly anxious patient or to place a comforting arm around a sobbing patient. The regular staff therapist tends to become involved in pulling the various interactions together, in finding the common thread or theme, in keeping the discussion relevant to the group, and in preventing the fragmentation that results in patients' dissatisfaction and disgust. The staff leader may point out dynamics while keeping the focus on feelings and attempting to minimize the intellectualizations related to the cognitive aspects of problem solving. At the end of each session, the group leader summarizes the essence and meaning of what took place to reinforce the patients' attempts at understanding their interpersonal relationships. Immediately after each session, the leader and facilitators analyze what went on to gain consensus and understanding concerning the nature of the interactions, and to plan approaches for the next session.

APPLICATIONS

It might be feared that a group of ten patients would tend to be overwhelmed by the presence of four facilitators and a leader. However, stimulation, not intimidation, appears to be the principal effect. Young male patients become responsive to the interest shown in them by the young female facilitators. The young female patients are piqued by the attentiveness of the young male facilitators. Patient mothers and facilitator mothers tend to compare experiences and viewpoints regarding the handling of difficult husbands, child-rearing problems, and family crises.

For the most part, patients are initially either confused or evasive about their difficulties, or defend themselves against fear of blame for their actions by denial. Typically they are preoccupied in the beginning with recollections of harsh and exploitative treatment by board-and-care home operators, the harassment of malicious neighbors, and unprovoked beatings by husbands.

The physical proximity of the members of the facilitator group to the members of the patient group encourages social relatedness. Private comments are readily picked up and brought out for general group discussion. The interspersing of the facilitators among the patients tends to control highly agitated and potentially assaultive patients. Frightening and destructive verbal fights can be quickly dampened by the facilitators' presence or intervention. In groups led by solitary therapists, there have been occasions when physical clashes have erupted, leaving both patients and

therapists extremely upset, and sometimes irreparably damaging group morale. In the multidisciplinary group the several therapists can readily intervene and relieve an explosive situation and, if necessary, intercede to forestall a physical clash. Some of the revolving-door patients get into such a high state of tension and anxiety that they cannot tolerate remaining in the group. In such an instance, the solitary therapist is left to decide between allowing both the remaining group and the fleeing patient to remain disturbed, or going after the patient with the group feeling abandoned. In the multidisciplinary situation, one therapist brings the patient back to work through the anxiety or remains with the patient outside the group if necessary. The therapy group is freed enough from concern about the precipitous departure to permit it to carry on therapeutic work. Thus in the multidisciplinary group, disrupting upsets are reduced, group security enhanced, and feelings of mutual protectiveness are developed.