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Inpatient Group Psychotherapy: Predicting Attendance and Participation

Sharon E. Silverberg
Old Dominion University

INPATIENT GROUP PSYCHOTHERAPY:

PREDICTING ATTENDANCE AND PARTICIPATION

by

Sharon E. Silverberg
B.S., Old Dominion University, 1998
B.S., Old Dominion University, 1998
M.A., University of New Haven, 2003

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Approved by:

Theodore P. Remley, Jr. (Chair)

Renee Seav (Member)

Garrett McAuliffe (Member)

ABSTRACT

INPATIENT PSYCHOTHERAPY GROUPS:
PREDICTING ATTENDANCE AND PARTICIPATION

Sharon Elizabeth Silverberg
Old Dominion University, 2010
Dissertation Chair: Dr. Theodore P. Remley, Jr.

Inpatient group psychotherapy is one of the primary talk therapy interventions offered to patients necessitating acute psychiatric treatment. Research indicates that patients who attend and participate in group psychotherapy sessions while admitted to psychiatric hospitals have a lower rate of recidivism and are more successful in the community utilizing lower levels of psychiatric care. Unfortunately, not all patients attend group psychotherapy while admitted to a psychiatric facility and therefore do not benefit, possibly contributing to non-compliance with community-based treatment and readmissions to inpatient psychiatric institutions for stabilization and safety. This lack of participation in group psychotherapy deprives the patient the opportunity to share thoughts and feelings related to the stressors and issues leading to the psychiatric inpatient admission. It also denies the patient opportunities to engage additional supports and learn coping skills to better deal with stressors in the future to prevent additional psychiatric inpatient hospitalizations.

The intention of this study was to determine whether demographic and clinical characteristics of patients admitted to private psychiatric hospitals can be used to predict attendance and participation in psychotherapy groups. The data were archival based on 150 randomly selected patients' records from patients admitted to a hospital over a one

year span (June 2009-May 2010). Forward step hierarchical regression and chi-square were the statistics used to analyze the data for this study. Findings indicated that patients who were diagnosed with co-morbid disorders, prescribed antipsychotic medications, or not compliant with taking prescribed psychotropic medications were more likely to not attend or not participate in psychotherapy groups offered while psychiatrically hospitalized. The following characteristics of patients were not associated with their attendance or participation in psychotherapy groups while hospitalized: age, marital status, ethnicity, gender, socio-economic status, suicidal ideation, homicidal ideation, psychosis, diminished capacity, length of admission, number of readmits, history of prior admissions, Five Axis diagnosis, Global Assessment of Functioning (GAF) intake, GAF discharge, substance abuse history, anti-depressant medications, anti-anxiety medications, mood stabilizer medications, sedative medications, psycho-stimulant medications, and hypnotic medications. The results of the analysis also indicate that there is a relationship between leader credentials and patients' attendance and participation in offered psychotherapy groups. However, there was no relationship between topics presented and patients' attendance and participation.

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Dr. Garrett McAuliffe

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CHAPTER ONE

INTRODUCTION

Statement of the Problem

Over the last several decades, inpatient psychiatric hospitals have evolved from long term psychiatric care to short term acute psychiatric treatment (Baker & Geise, 1992; Springer & Silk, 1996; Vaughn et al., 1995). Currently in the United States, individuals admitted to a psychiatric hospital typically stay an average length of between 7 to 12 days, or until they can be safely treated at a lower level of care (e.g., outpatient treatment or partial inpatient treatment) and safely maintain in the community (Compton, Craw, & Rudisch, 2006). While a patient is admitted to a psychiatric facility, the primary focus is placed on medication management (Yalom, 1983). Since psychopharmacology is the primary therapeutic focus for psychiatric patients, not psychotherapy, and in combination with the large number of patients admitted to a psychiatric hospital at any given time, individual psychotherapy is typically not offered for each patient (Santa Ana et al., 2007).

Group psychotherapy is the primary talk therapy offered to patients while admitted to a psychiatric inpatient facility (Farley, 1998; Strauss & Burgmeier-Lohse, 1994; Tschuschke, 2004; Weiss, 2010; Yalom, 1983). Research has shown that it is beneficial for patient outcomes post discharge if they participate in group psychotherapy while admitted to a psychiatric hospital (Page & Hooke, 2009). Unfortunately, not all patients chose to attend group psychotherapy sessions offered while admitted to the psychiatric facility and therefore do not benefit. This lack of participation in group psychotherapy deprives the patient the opportunity to share thoughts and feelings related

to the stressors and issues leading to the psychiatric inpatient admission (Vaughn et al., 1995). It also denies them of the chance to receive additional support in learning coping skills to better deal with stressors in the future, thereby possibly preventing additional psychiatric inpatient hospitalizations (Blake et al., 1990; Dacey, 1989).

Group psychotherapy plays a large role in patients' recovery while admitted to a psychiatric hospital and their success upon discharge (Page & Hooke, 2009). Therefore, it is important to understand what clinical factors contribute to a patient's participation and attendance of inpatient group psychotherapy. The ability to predict a person's attendance and participation in inpatient group psychotherapy will help staff members identify those who may need additional support and encouragement to attend. Behavioral strategies, such as verbal instructions and feedback, have been studied and shown to significantly increase patient's attendance in inpatient group therapy (Blake, Owens, & Keene, 1990). This assistance may increase the likelihood of the patients attending psychotherapy groups while admitted to the hospital, even as early as the first day. Moreover, it may also increase the likelihood of success upon discharge into the community to a lower level of care and decrease the rate in inpatient psychiatric admission recidivism.

Rationale for the Study

Inpatient group psychotherapy has been shown to be effective and makes efficient use of the patients' time and the hospital and staff's resources (Kösters et al., 2006; Yalom, 1983). Research also has indicated that group therapy in an inpatient setting has been effective in predicting a positive outcome for a patient's post discharge (Page & Hooke, 2009). This study will help to identify characteristics in patients that lead to non-

attendance or non participation in group therapy while admitted to the psychiatric facility. The information gleaned from this study may increase the ability of hospital staff to engage patients who may have characteristics predictive of not attending or participating in group therapy. Increasing attendance and participation in in-patient group therapy sessions would help in providing a more positive outcome for a patient's future success in the community.

Upon examination of the literature, there is a large gap in the scholarly research focused on characteristics of patients who engage in and benefit from inpatient group therapy. Due to decreased availability of beds and length of stay in psychiatric inpatient facilities, it is important to maximize the therapeutic benefit to the admitted patient to help decrease recidivism. This study will contribute to the limited literature in the counseling field regarding inpatient group therapy and stimulate future research.

Purpose of the Study

The purpose of this study is to examine possible predictive factors contributing to a patient's attendance and participation of inpatient psychotherapy groups by utilizing historical data. Data included demographic information (gender, race, age, ethnicity, and SES); admission status (voluntary versus involuntary); DSM-IV TR diagnosis (Axis I, II, III, IV, and IV); compliance of current prescribed types of medications (antidepressants, antipsychotics, etc.); number of days admitted; number of admissions during the time period of the study (one year); attendance and participation as documented by hospital staff on group therapy progress notes; topics presented in the group therapy sessions; and the credentials of the mental health providers leading the group therapy sessions.

Definitions of Terms

Psychiatric Hospital: A hospital solely for the purpose of providing psychiatric care, to include medication management and psychotherapy, for patients who are unable to remain safe in the community due to mental health impairments.

Inpatient Psychiatric Treatment: Acute psychiatric hospitalization for patients in danger of harming themselves or others, or who are unable to care for themselves in the community, based on mental health impairment.

Involuntary Inpatient Admission: Status of a patient admitted to a psychiatric hospital involuntarily. Patient deemed unable to consent to treatment or who refused the inpatient treatment option at admission.

Voluntarily Inpatient Admission: Status of a patient admitted to a psychiatric hospital voluntarily. Patient must be deemed able to consent to treatment at the time of admission.

Group Psychotherapy: Therapy in a group format made up of individuals with similar problems or stressors, led by a mental health professional. Group members work through personal issues and concerns within the group in order to gain perspective and receive peer support.

Inpatient Group Psychotherapy: A therapeutic milieu created in an inpatient setting for patients who are currently hospitalized to attend group therapy with other patients experiencing similar stressors in order to work through issues which led to being hospitalized.

CHAPTER TWO

REVIEW OF THE LITERATURE

Group Psychotherapy Treatment

Group psychotherapy began after World War I in the 1920s in North America. It was at this time that Edward L. Lazell began working with war veterans diagnosed with schizophrenia at St. Elizabeth's Hospital in Washington, D.C. Lazell (1921) stated that group psychotherapy assisted patients with increased socialization and decreased fears regarding the therapist. In 1931, L. Cody Marsh worked with groups of patients hospitalized in Massachusetts utilizing group exercises and activities to help patients with their rehabilitation (Kibel, 1992). In 1983, Irvin Yalom developed a method of inpatient group therapy at Stanford University. Yalom's focus on inpatient psychotherapy was based around a dynamic approach to a patient's interpersonal learning with special attention to the *here and now* (1983).

Group psychotherapy has been shown to be an effective treatment intervention for patients suffering from psychiatric illness including Mood Disorders (Burlingame & Barlow, 1996; Kuhns, 1997; Murphy, 1997; McNamee et al., 1995; Scott & Stradling, 1990), Obsessive-Compulsive Disorder (Van Noppen et al., 1998), Social Phobias (Fanget, 2000; Heimberg et al., 1998; Hope et al.; 1995; Scholing & Emmelkamp, 1993), and Eating Disorders (Davis et al., 1990; Davis et al., 1997; Hartmann et al., 1992; Mitchell et al., 1993; Peterson et al., 1998).

Group psychotherapy integrates both the interpersonal and interactional climate established and maintained by the group itself (Lambert, 2004). Participating in group psychotherapy creates a sense of value in the patient. The group member's interactions with each other are the primary delivery of the change that will bring about a positive

affect (Furhiman & Burlingame, 1990). After decades of research, group psychotherapy treatment has shown to be effective even as a sole intervention for some patients suffering from psychiatric illness (Fuhriman & Burlingame, 1994).

Inpatient Treatment

Inpatient psychiatric hospitals have evolved over the last 40 years from long-term psychiatric care facilities to a short term acute psychiatric treatment option (Baker & Geise, 1992; Kibel, 1992; Springer & Silk, 1996; Vaughn et al., 1995). According to Yalom (1983), this shift was caused by increased knowledge and effectiveness of psychopharmacology, the creation of crisis theory, and the decreased use of somatic therapies. Yalom also stated that, prior to this shift in psychiatric inpatient treatment, psychiatric patients experienced admissions to remote state psychiatric wards for a prolonged period of time and had lower recidivism rates.

Spivack (2008) pointed out that the "primary task of the short-term unit is the rapid stabilization and discharge of patients who are attempting to recover from acute episodes of mental illness." Compton et al. (2006) agreed that in the last decade, much attention has been placed on length of stay due to funding agencies (e.g., managed care; Farkas-Cameron, 1998; Weiss, 2010), administrative costs of care, and the focus of treating patients in the least restrictive setting appropriate for their psychiatric care. Currently, individuals admitted to a psychiatric hospital in the United States typically stay an average length of between 7 to 12 days, until the patient is able to be safely treated at a lower level of care (e.g., outpatient treatment or partial inpatient treatment) in the community (Compton, Craw, & Rudisch, 2006).

During a patient's admission to a psychiatric facility, the primary focus is placed on medication management (Yalom, 1983). Other than medications, treatment modalities offered to patients may include art therapy, recreational therapy, and group psychotherapy. However, group psychotherapy is the typically the only consistent psychotherapy offered to patients while admitted to a psychiatric hospital (Rhea, 1977).

Inpatient Psychotherapy Group Treatment

Inpatient group psychotherapy has been recognized as an important element in treating individuals suffering from acute mental illness (Brabender & Fallen, 1993; Kösters et al., 2006; Seidler, 2000; Yalom, 1983). Yalom created a structured and stylized method of group therapy for the inpatient setting in 1983 taking a *utilitarian and non-analytic* approach (Kibel, 1992). Yalom's style of inpatient group psychotherapy addressed issues for the mildly mentally ill as well as the severely mentally ill, so that all patients would benefit from group psychotherapy while admitted in the hospital (1983).

In 1977, Parloff and Dies acknowledged the expansive role that group psychotherapy was beginning to take in the treatment of patients admitted to a psychiatric hospital. Currently, group psychotherapy is the primary and preferred talk therapy offered to patients when admitted to a psychiatric inpatient facility (Farley, 1998; Strauss & Burgmeier-Lohse, 1994; Tschuschke, 2004; Weiss, 2010; Yalom, 1983). Given the shortened length of stay (7-12 days) for patients to be admitted to psychiatric hospitals, utilizing group psychotherapy as a primary therapeutic intervention utilizes not only clinical effectiveness but also involves the highest number of patients per group psychotherapy intervention (Yalom, 1995).

Yalom believed that issues raised during a group psychotherapy session on an inpatient unit must be addressed at that time due to the time sensitive nature and short admissions. Patients may have the opportunity to participate in only one group, or several groups (Weiss, 2010) depending on their length of stay at the psychiatric facility and their attendance of group sessions offered while hospitalized (Vaughn et al., 1995).

In an inpatient setting, group psychotherapy acts as a strong therapeutic intervention due to the positive effect it has on a patient's progress towards discharge. One positive effect of inpatient psychotherapy groups is their ability to facilitate improvement in a patient's social interaction skills (Schindler, 1999). Other therapeutic benefits that are implemented in a single group inpatient psychotherapy session time-frame include patient support from staff and peers and encouraged involvement in the session, both of which provide structure (Yalom, 1983; Yalom & Leszcz, 2005) as well as feelings of safety and trust (Farkas-Cameron, 1998).

Research has established that there aret positive patient outcomes for those who participate in group psychotherapy while in inpatient treatment (Kösters et al., 2006; Page & Hooke, 2009). Farkas-Cameron (1998) further added that it is an important therapeutic goal to create a positive experience for patients participating in group psychotherapy while admitted to a psychiatric hospital so that they will want to continue with group psychotherapy upon discharge in the community.

Summary

It is widely acknowledged that inpatient group therapy has been demonstrated to be effective (Farkas-Cameron, 1998; Kanas, 1985; Kösters et al., 2006; Page & Hooke, 2009; Yalom, 1983) and makes efficient use of the patients' time and the hospital and

staff resources (Yalom, 1983). Research indicates group therapy in an inpatient setting has shown effectiveness in predicting a positive outcome for patients' post discharge as well as decreasing rates of recidivism (Page & Hooke, 2009). Unfortunately, not all patients attend group psychotherapy while admitted to the psychiatric facility and therefore do not benefit (Vaughn et al., 1995). This lack of participation in group psychotherapy deprives the patient the opportunity to share thoughts and feelings related to the stressors and issues leading to the psychiatric inpatient admission. It also denies them of supports and learning coping skills to better deal with stressors in the future to prevent additional psychiatric inpatient hospitalizations (Dacey, 1989).

Upon examination of the literature, there is a large gap in the scholarly research focused on characteristics of patients who engage in and benefit from inpatient group therapy. Due to decreased availability of beds and length of stay in psychiatric inpatient facilities, it is important to maximize the therapeutic benefit to the patient while admitted to help decrease recidivism. This study will seek to determine whether patient attendance and participation in inpatient group psychotherapy sessions can be predicted.

CHAPTER THREE

METHODOLOGY

This chapter introduces the methodology that was used in exploring the predictive relationship between patient (1) characteristics and (2) attendance and participation with inpatient psychotherapy groups. It includes a description of the research design, a review of the research questions, population and participant selection procedures, and data collection and analyses. Finally, the limitations of this research study are delineated.

Quantitative Research Design

Purpose of Study

The purpose of this study was to examine possible factors that might predict a patient's attendance and participation in inpatient psychotherapy groups by utilizing historical data. Data examined included demographic information (gender, race, age, ethnicity, and social and economic status); admission status (voluntary versus involuntary); DSM-IV TR diagnosis (Axis I, II, III, IV, and IV); compliance with current prescribed types of medications (antidepressants, antipsychotics, etc.); number of days admitted, number of admissions during the time period of the study (one year); attendance and participation as documented on group therapy progress notes; topics presented in the group therapy sessions; and the credentials of the mental health providers leading the group therapy sessions.

Research Questions and Hypotheses

The research questions and hypotheses that were addressed in this study were as follows:

Research Question 1: To what degree do the clinical characteristics of admission status, diagnosis, medications, previous psychiatric inpatient admissions, and number of days admitted predict a patient's attendance in inpatient psychotherapy groups?

Hypothesis 1:

- 1: There is a significant relationship between clinical characteristics and a patient's attendance in psychotherapy group treatment while psychiatrically hospitalized.

Research Question 2: To what degree do the following variables of admission status, diagnosis, medications, previous psychiatric inpatient admissions, and number of days admitted predict a patient's participation in inpatient psychotherapy groups?

Hypothesis 2:

- 2: There is a significant relationship between clinical characteristics and a patient's participation in psychotherapy group treatment while psychiatrically hospitalized.

Research Question 3: To what degree do the group psychotherapy facilitator credentials predict a patient's participation or attendance in inpatient psychotherapy groups?

Hypothesis 3:

- 3: There is a significant relationship between the group psychotherapy facilitator credentials and a patient's participation and attendance in psychotherapy group treatment while psychiatrically hospitalized.

Research Question 4: To what degree do the topics presented in the group psychotherapy session predict a patient's participation or attendance in inpatient psychotherapy groups?

Hypothesis 4:

- 4: There is a significant relationship between the topics presented in the group psychotherapy session and a patient's participation and attendance in psychotherapy group treatment while psychiatrically hospitalized.

Participants

Patients were randomly selected from a data base of approximately 2,000 patients admitted over the last calendar year. Patients were selected at random using a random number generator and applying the results to a spread sheet list of all patients provided by an administrative staff member at a private psychiatric hospital in the mid-Atlantic region of the United States. Patients selected included adults 18-65 admitted for mental health issues. According to Cohen (1992), assuming a moderate effect size at the p=.80 level, a minimum sample of 107 patients were needed to have adequate power for hypotheses that are tested at the .05 alpha level. In order to strengthen the study, records of 150 patients were utilized in the data collection process.

Instrumentation

I created an instrument in the form of a Microsoft Excel Document to collect and record pertinent historical data for the data retrieved from the patients' charts. There was an anonymous code given to each patient whose information was used in this data collection process. The information collected was taken from admission and discharge assessments and evaluations from multiple sources. These sources included, but were not limited to, psychiatrist admission and discharge assessments, social work assessments, temporary detention order (TDO) prescreen assessments, and group therapy progress notes.

The following information was obtained for the purposes of this research study from the patients' charts and documented by me.

(1) Demographics (*gender, age, marital status, SES*)

(2) Diagnoses (*Axis I, II, III, IV*)

(3) Mental Status (*suicidality, homocidality, psychosis, etc.*)

(4) Substance Abuse History

(5) Medical Conditions (*Current or relevant past conditions [e.g. traumatic brain injury]*)

(6) Number of psychotherapy groups offered

(7) Number of psychotherapy groups attended in part or whole

(8) Quality of participation in the psychotherapy groups attended based on progress note documentation (*not attended, actively engaged, passively engaged, not engaged*)

(9) Credentials of group facilitators (*MA, MSW, LCSW, LPC*)

(10) Group psychotherapy topic categories presented by facilitators (*general process, self- awareness, coping skills, grief and loss, anger management, relaxation exercises, healthy relationships, problem solving*)

Participant ID Sheet

Participant ID's were utilized to ensure confidentiality. No names were written on the data collection sheets. Participants were assigned an ID based on the order chart received during the random selection process.

Procedure

Patients were randomly selected from a data base of approximately 2,000 patients admitted over the last calendar year by an administrative staff member at a private hospital in the Southern part of the United States. Data on patients admitted between June 1, 2009 and May 31, 2010 were collected and assigned a number starting with the number one. A random number generator was utilized to randomly select 150 numbers; the data from patients who had corresponding ID numbers were used for the study. Patients selected for the study included adults 18 to 65-years-old admitted to the psychiatric hospital primarily for mental health issues needing acute care for stabilization and community safety. Data was collected on-site at the psychiatric hospital. I recorded the information on a digital version of the record sheet with no identifying information in the file. I gathered and recorded the participants' information in a private room. The flash drive and spread sheets were stored in a locked file cabinet to ensure complete confidentiality. The data was protected by a fingerprint pass code security feature on a 4MB external flash drive.

Data Analysis

The study used a correlational design where the goal was to predict group attendance and participation from several individual difference variables. Data was analyzed by using SPSS (version 17) software. Frequency distributions were utilized to report data such as gender, age, race/ethnicity, diagnosis, admission status, prescriptions taken during admission, and number of group therapy sessions offered, attendance, and quality of attendance. Correlations were completed to examine the significant relationships between demographic variables and the predictor variables. Regressions were used to

test the hypothesis. Demographic variables found to be significantly related to any predicted or outcome variable were included in the regression.

Validity Threats

Creswell cited many potential threats to internal and external validity when conducting research (2009). He stated "internal validity threats are experimental procedures, treatments, or experiences of the participants that threaten the researcher's ability to draw correct inferences from the data about the population in an experiment" (p. 230). Internal validity is also defined as the ability of the research design to rule out or make alternative explanations of the results (Marczyk, Dematteo, & Festinger, 2005). Selection is a type of validity threat that could pose a threat to this study. To reduce this validity threat, patients were randomly selected for the study using a random number generator and a spreadsheet of the patients provided by a hospital administrative staff member who had no direct patient contact and was not aware of the goals of this study.

External validity is defined by how generalizable the results of the research study can be applied to the population (Marczyk et al., 2005). Creswell (2009) stated that external validity threats "arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and past or future situations" (p. 162). This type of validity threat may be a problem due to characteristics of the participants, timing of the experiment, and uniqueness of setting. The interaction of the setting and treatment may be an issue in this study. Characteristics of the participants may prevent the results from being generalized to individuals in other settings. Therefore, generalizability of the results of this study may be limited.

Potential Contributions

Upon examination of the literature, there is a large gap in the scholarly research focused on characteristics of patients who engage in inpatient group therapy. Due to decreased availability of beds and shortened length of stay in psychiatric inpatient facilities, it is important to maximize the therapeutic benefit to the patient while admitted to help decrease recidivism. This study contributed to the limited literature in the mental health field regarding inpatient group therapy and hopefully will stimulate additional research studies on this topic.

CHAPTER FOUR

The intention of this study was to examine the clinical characteristics of patients admitted to a private inpatient psychiatric hospital to determine possible predictors of group psychotherapy attendance and participation. A total of 150 patients' charts were randomly selected for the study. The data were archival and collected from patients' documented psychiatric reports, progress notes, and nursing reports organized in clinical charts housed onsite at the inpatient facility. The data were then coded for analysis, the data were entered into SPSS, and forward stepwise hierarchical regressions, Pearson's Correlation Coefficient, and chi-square analyses were conducted. The predictor variables of this study were demographic variables, clinical diagnostic variables, leader credentials, and topics presented in the psychotherapy group. The criterion variables were attendance and participation in the inpatient psychotherapy group. The results of the study are presented in this chapter.

Data Review

Data were collected over a period of six weeks onsite at the psychiatric hospital. The data collection process was lengthy. Each physical chart was thoroughly reviewed for specific clinical information documented by clinical and paraprofessional staff, including intake reports, discharge summaries, physician reports, medication administration documentation, and individual group psychotherapy progress notes.

The Health Information Services (HIS) department supervisor of the psychiatric hospital was integral in the data collection process. Prior to data collection, the HIS supervisor provided a spread sheet with the patients' names and identifying record numbers admitted the duration the study was examining. This spreadsheet was used to

identify the patients randomly selected for the study by a random number generator. The HIS supervisor permitted unlimited access to the chart room where patients' charts were housed and she reserved physical space for the researcher where the data was collected. The HIS supervisor was accessible, extremely helpful, supportive, and readily able to answer questions that arose during the data collection process.

The chart room was very well organized and patients' charts were easily found, often with several charts per patient based on the number of admissions the previous year. Each patient's chart was organized consistently and information was complete. As expected, physicians', psychiatrists', nurses', and clinicians' progress notes and forms were filled out thoroughly with the information needed for the study. Psychiatric histories were detail oriented and clearly documented patients' psychosocial stressors and psychiatric issues relevant to the admission, as well as their histories of prior inpatient and outpatient psychiatric treatment interventions. Group psychotherapy progress notes were also thoroughly documented with group topics, patients' responses to the group process, and often mentioned alternative interventions attempted by group psychotherapy leaders for patients not in attendance during the offered group psychotherapy session.

It was noted in the chart review that the level of detail in the documentation, specifically group psychotherapy notes, increased with admission after January 1, 2010. The HIS supervisor stated this was due to internal changes to improve documentation and remain in compliance with managed care providers. This allowed a greater amount of information to be extracted from the group psychotherapy notes.

Findings

Frequency tables and descriptive statistics for the data collected were calculated to identify any discrepancies in the data. The means and standard deviations were within appropriate ranges and are presented in Tables 1, 2, and 3.

Table 1

Descriptive Demographic Characteristics

Characteristics	Number (Percent)
N	150
Age	
Range	18-65
Mean Age	37.45
Gender	
Male	61 (40.7)
Female	89 (59.3)
Ethnicity	
Caucasian	103 (68.7)
African American	38 (25.5)
Hispanic	7 (4.7)
Asian	2 (1.3)
SES	
Insured	123 (82)
Uninsured	27 (18)
Marital Status	
Single	81 (54)
Married	2 (34.7)
Divorced	13 (8.7)
Widowed	4 (2.7)

Table 2

Descriptive Admission Clinical Characteristics I

Characteristics	Yes Number/(Percent)		No Number/ (Percent)	
Voluntary Admit Status	83	(55.3)	67	(44.7)
History of Prior Admits	69	(46)	81	(54)
Substance Abuse History	68	(45.3)	81	(54)
Medication Compliant	141	(94)	9	(6)
Suicidal Ideation	110	(73.3)	40	(26.7)
Homicidal Ideation	11	(7.3)	139	(92.7)
Psychosis	74	(49.3)	76	(50.7)
Diminished Capacity	21	(14)	129	(86)
Axis I Co-morbidity	82	(54.7)	68	(45.3)
Anti-Depressants	103	(68.7)	47	(31.3)
Anti-Anxiety	45	(30)	105	(70)
Mood Stabilizers	60	(40)	90	(60)
Anti-Psychotics	99	(66)	51	(34)
Sedatives	3	(2)	147	(98)
Psycho-stimulants	4	(2.7)	146	(97.3)
Hypnotics	23	(15.3)	127	(84.7)

Table 3

Descriptive Admission Clinical Diagnosis Characteristics

Characteristics	Number/(Percent)	Mean (SD)
Axis I		
Mood/Depressive Disorders	78 (52)	
Bipolar Disorders	32 (21.3)	
Schizophrenia/Psychotic Disorders	40 (26.7)	
Axis II		
No Diagnosis	97 (64.7)	
Mental Retardation (MR) Diagnosis	4 (2.7)	
Personality Disorder (PD) Diagnosis	49 (32.7)	
Axis III		
Medical Stressors		1.09 (1.27)
Axis IV		
Low	40 (24.7)	
Moderate	22 (14.7)	
Severe	88 (58.7)	
GAF Intake		30.94 (8.04)
GAF Discharge		53.51 (9.82)
Length of Stay		6.45 (4.22)
Re-Admits		0.29 (0.64)
Zero	118 (78.7)	
One	23 (15.3)	
Two	6 (4)	
Three	3 (2)	
Number of Psychotherapy Groups Offered		6.1 (4.04)
Number of Psychotherapy Groups Attended		3.33 (2.54)

Research Question One

Research Question One (Q1) asked, "To what degree do clinical characteristics of admission status, diagnosis, medications, previous psychiatric inpatient admissions, and number of days admitted predict a patient's attendance in inpatient psychotherapy groups?"

The hypothesis for Q1 was that there was a significant relationship between clinical characteristics and a patient's attendance in psychotherapy group treatment while psychiatrically hospitalized. The hypothesis was tested using a regression equation using the percentage of group attendance as the dependent variable and demographic (age, gender, socio-economic status, ethnicity, marital status) and clinical characteristics (Five Axis diagnoses, voluntary admission status, prior psychiatric inpatient admissions, substance abuse history, medication compliant, suicidal ideation, homicidal ideation, psychosis, diminished capacity, Axis I co-morbidity, type of medication, Global Assessment Functioning (GAF) at intake and discharge, length of stay, re-admissions, number of inpatient psychotherapy groups offered, and number of psychotherapy groups attended) as independent predictor variables. The percentage of attendance was the outcome variable calculated by dividing the total number of attended group by the total number of offered groups.

Since the literature provided little guidance on which variables are most important to predict group psychotherapy attendance, a forward stepwise entry method was used for the regression. In the first step, medication compliance was entered into the equation, producing an R^2 0.07. Patients who were compliant with their medications were more likely to attend group therapy (see Table 4). In the second step, having a prescription of

anti-psychotic medications was entered, producing an R^2 change of 0.033. Patients who were not on antipsychotic medications were more likely to attend group therapy. In the third step, having a comorbid Axis I diagnoses was entered, producing an R^2 change of 0.033. Patients who did not have comorbid Axis I diagnoses were more likely to attend group therapy. The overall model was significant, $F(3) = 7.76$, $p < 0.001$, and the R^2 for the model was 0.138. The results indicated three variables, medication compliance, prescription of anti-psychotic medications, and comorbid Axis I diagnoses were predictors of inpatient group psychotherapy attendance. There were no other variables that significantly predicted group attendance.

Table 4

Regression Equations Predicting Percentage of Groups Attended by Clinical Characteristics

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	Not Medication Compliant	-.361	.107	-.269	-3.384	.001
2	Not Medication Compliant	-.331	.106	-.246	-3.120	.002
	Prescribed Anti-Psychotic Medicines	-.124	.053	-.184	-2.333	.021
3	Not Medication Compliant	-.342	.105	-.255	-3.275	.001
	Prescribed Anti-Psychotic Medicines	-.140	.053	-.207	-2.649	.009
	Co-morbid Diagnoses	-.118	.050	-.183	-2.350	.020

Research Question Two

Research Question Two (Q2) asked, "To what degree do the following variables of admission status, diagnosis, medications, previous psychiatric inpatient admissions, and number of days admitted predict a patient's participation in inpatient psychotherapy groups?"

The hypothesis for Q2 was that there was a significant relationship between clinical characteristics and a patient's participation in psychotherapy group treatment while psychiatrically hospitalized.

The hypothesis was tested using a regression equation using the percentage of patient participation as the dependent variable and demographic (see Table 1) and clinical characteristics (see Tables 2 and 3) as independent predictor variables as referenced above for Q1. The percent of participation was the outcome variable. Average participation was calculated by a scoring non-attendance (0), disruptive behavior exhibited (1), not engaged (2) or actively engaged (3) for psychotherapy group offered, calculating a total, and dividing by the number of psychotherapy groups offered for each patient in the study.

As referenced in Q1, the literature provides little guidance on which variables are most important to predict group psychotherapy participation. A forward stepwise entry method was used to calculate the regression (Table 5).

Table 5

Regression Equations Predicting Percentage of Participation in Psychotherapy Groups by Clinical Characteristics

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	Prescribed Anti-Psychotic Medications	-.505	.153	-.263	-3.308	.001
2	Prescribed Anti-Psychotic	-.452	.150	-.236	-3.008	.003
	Not Medication Compliant	-.856	.299	-.224	-2.859	.005
3	Prescribed Anti-Psychotic	-.493	.150	-.257	-3.288	.001
	Not Medication Compliant	-.885	.296	-.232	-2.988	.003
	Comorbid Diagnoses	-.299	.142	-.164	-2.108	.037

In the first step, having a prescription of anti-psychotic medications was entered, producing an R^2 0.069. Patients who were not on antipsychotic medications were more likely to participate in attended group therapy. In the second step, medication compliance was entered into the equation, producing an R^2 change of 0.049. Patients who were compliant with their medications were more likely to participate in attended group therapy sessions. In the third step, having a comorbid Axis I diagnoses was entered, producing an R^2 change of 0.026. Patients who did not have comorbid Axis I diagnoses were more likely to participate in attended group therapy sessions. The overall

model was significant, $F(3) = 8.19$, $p = 0.037$, and the R^2 for the model was 0.145. The results indicated three variables, medication compliance, prescription of anti-psychotic medications, and comorbid Axis I diagnoses were predictors of inpatient group psychotherapy participation. There were no other variables that significantly predicted group participation.

Research Question Three

Research Question Three (Q3) asked, "To what degree do group psychotherapy facilitator credentials predict patients' participation or attendance in inpatient psychotherapy groups?"

The hypothesis for Q3 was that there was a significant relationship between the group psychotherapy facilitator credentials and patients' participation and attendance in psychotherapy group treatment while psychiatrically hospitalized. The hypothesis was tested using a Pearson Chi-Squares test. Results of the analysis showed that inpatient group psychotherapy attendance was dependent on of the credentials of the facilitator, $\chi^2(3) = 10.94$, $p < .05$ (see Table 6). This suggests that patients attended more groups than expected that were facilitated by clinicians with a aster in social work (MSW) degree and fewer groups than expected for facilitators with a master of art (MA) degree, Licensed Professional Counselor (LPC), or Licensed Clinical Social Worker (LCSW) credentials.

Table 6

Chi-Square of Attendance Frequency by Leader Credentials

Leader Credentials		Attendance		Total
		Yes	No	
MSW	Count	218	143	361
	Expected Count	196.1	164.9	361.0
	% of Total	23.9%	15.7%	39.5%
	Std. Residual	1.6	-1.7	
MA				
	Count	104	111	215
	Expected Count	116.8	98.2	215.0
	% of Total	11.4%	12.2%	23.5%
	Std. Residual	-1.2	1.3	
LCSW				
	Count	165	150	315
	Expected Count	171.1	143.9	315.0
	% of Total	18.1%	16.4%	34.5%
LPC	Std. Residual	-.5	.5	
	Count	9	13	22
	Expected Count	12.0	10.0	22.0
	% of Total	1.0%	1.4%	2.4%
	Std. Residual	-.9	.9	
Total	Count	496	417	913
	Expected Count	496.0	417.0	913.0
	% of Total	54.3%	45.7%	100.0%

Pearson Chi-Square results also indicated that there was a significant relationship between leader credentials and participation. Results of the analysis showed that

inpatient group psychotherapy participation was dependent on of the credentials of the facilitator, χ^2 (9) = 23.71, $p < .01$ (see Table 7). This suggests patients were more engaged than expected in psychotherapy groups facilitated by clinicians with a MSW and LCSW and less engaged in psychotherapy groups with MA and LPC facilitators.

Table 7

Chi-Square of Participation Frequency by Leader Credentials

Leader Credentials		Participation				
		Did Not Attend Offered Group	Disruptive	Not Engaged	Actively Engaged	Total
MSW	Count	143	11	39	168	361
	Expected Count	165.3	16.6	34.8	144.3	361.0
	% of Total	15.7	1.2	4.3	18.4	39.5
	Std. Residual	-1.7	-1.4	.7	2.0	
MA	Count	112	15	24	64	215
	Expected Count	98.4	9.9	20.7	86.0	215.0
	% of Total	12.3	1.6	2.6	7.0	23.5
	Std. Residual	1.4	1.6	.7	-2.4	
LCSW	Count	150	15	23	127	315
	Expected Count	144.2	14.5	30.4	125.9	315.0
	% of Total	16.4	1.6	2.5	13.9	34.5
	Std. Residual	.5	.1	-1.3	.1	
LPC	Count	13	1	2	6	22
	Expected Count	10.1	1.0	2.1	8.8	22.0
	% of Total	1.4	0.1	0.2	0.7	2.4
	Std. Residual	0.9	.0	-0.1	-0.9	
Total	Count	418	42	88	365	913
	Expected Count	418.0	42.0	88.0	365.0	913.0
	% of Total	45.8	4.6	9.6	40.0	100.0%

Research Question Four

Research Question Four (Q4) asked, "To what degree do the topics presented in the group psychotherapy session predict a patient's participation or attendance in inpatient psychotherapy groups?"

The hypothesis for Q4 was that there was a significant relationship between the topics presented in the group psychotherapy session and a patient's participation and attendance in psychotherapy group treatment while psychiatrically hospitalized. The hypothesis was tested using a Pearson Chi-Squares test. The results indicated that there was no significant relationship between topics presented and patients' attendance in psychotherapy groups (see Table 8), χ^2 (7) = 11.91, $p < .10$ or patients' participation in psychotherapy groups (see Table 9), χ^2 (21) = 24.64, $p < .26$.

Table 8

Chi-Square of Attendance Frequency by Group Psychotherapy Topic

		Attendance		
Topic		Yes	No	Total
General Process	Count	95	114	209
	Expected Count	113.5	95.5	209.0
	% of Total	10.4	12.5	22.9
	Std. Residual	-1.7	1.9	
Self-Awareness	Count	117	83	200
	Expected Count	108.7	91.3	200.0
	% of Total	12.8	9.1	21.9
	Std. Residual	.8	-.9	
Coping	Count	139	110	249
	Expected Count	135.3	113.7	249.0

	% of Total	15.2	12.0	27.3
	Std. Residual	.3	-.3	
Grief and Loss	Count	5	4	9
	Expected Count	4.9	4.1	9.0
	% of Total	.5%	.4%	1.0%
	Std. Residual	.1	-.1	
Anger Management	Count	15	9	24
	Expected Count	13.0	11.0	24.0
	% of Total	1.6	1.0	2.6
	Std. Residual	.5	-.6	
Relaxation Exercises	Count	26	13	39
	Expected Count	21.2	17.8	39.0
	% of Total	2.8	1.4	4.3
	Std. Residual	1.0	-1.1	
Healthy Relationships	Count	61	47	108
	Expected Count	58.7	49.3	108.0
	% of Total	6.7	5.1	11.8
	Std. Residual	.3	-.3	
Problem Solving	Count	38	37	75
	Expected Count	40.7	34.3	75.0
	% of Total	4.2	4.1	8.2
	Std. Residual	-.4	.5	
Total	Count	496	417	913
	Expected Count	496.0	417.0	913.0
	% of Total	54.3	45.7	100.0

Table 9

Chi-Square of Participation Frequency by Group Psychotherapy Topic

Topics		Participation				Total
		Did Not Attend Offered Group	Disruptive	Not Engaged	Actively Engaged	
General Process	Count	114	8	21	66	209
	Expected Count	95.7	9.6	20.1	83.6	209.0
	% of Total	12.5	.9	2.3	7.2	22.9
	Std. Residual	1.9	-.5	.2	-1.9	
Self-Awareness	Count	83	7	18	92	200
	Expected Count	91.6	9.2	19.3	80.0	200.0
	% of Total	9.1	.8	2.0	10.1	21.9
	Std. Residual	-.9	-.7	-.3	1.3	
Coping	Count	110	14	23	102	249
	Expected Count	114.0	11.5	24.0	99.5	249.0
	% of Total	12.0	1.5	2.5	11.2	27.3
	Std. Residual	-.4	.8	-.2	.2	
Grief and Loss	Count	4	0	0	5	9
	Expected Count	4.1	.4	.9	3.6	9.0
	% of Total	.4	.0	.0	.5	1.0
	Std. Residual	-.1	-.6	-.9	.7	
Anger Management	Count	10	2	4	8	24
	Expected Count	11.0	1.1	2.3	9.6	24.0
	% of Total	1.1	.2	.4	.9	2.6
	Std. Residual	-.3	.9	1.1	-.5	
Relaxation Exercise	Count	13	2	5	19	39
	Expected Count	17.9	1.8	3.8	15.6	39.0

	% of Total	1.4	.2	.5	2.1	4.3
	Std. Residual	-1.1	.2	.6	.9	
Healthy Relationships	Count	47	5	15	41	108
	Expected Count	49.4	5.0	10.4	43.2	108.0
	% of Total	5.1	.5	1.6	4.5	11.8
	Std. Residual	-.3	.0	1.4	-.3	
Problem Solving	Count	37	4	2	32	75
	Expected Count	34.3	3.5	7.2	30.0	75.0
	% of Total	4.1	.4	.2	3.5	8.2
	Std. Residual	.5	.3	-1.9	.4	
Total	Count	418	42	88	365	913
	Expected Count	418.0	42.0	88.0	365.0	913.0
	% of Total	45.8	4.6	9.6	40.0	100.0

CHAPTER FIVE

DISCUSSION

The analysis and results of this study are presented in Chapter Five. The statistical outcomes, limitations, implications for counselors, counselor educators, and future research are discussed. The data analyses suggest that further research on inpatient group psychotherapy attendance and participation is needed.

The purpose of this study was to examine inpatient psychotherapy groups and predictive factors contributing to patients' attendance and participation based on clinical characteristics, facilitator credentials, and topics presented.

Research indicates that patients' attendance and participation in group psychotherapy while admitted to inpatient psychiatric facilities decreases recidivism and increases coping skills upon reintegration into the community (Kösters et al., 2006; Page & Hooke, 2009). This study focused on examining historical data from the charts of 150 patients' charts admitted to an inpatient psychiatric facility from June 2009 to May 2010. The goal was to predict relationships between clinical characteristics and inpatient psychotherapy group attendance and participation. The data examined included demographic information (gender, race, age, ethnicity, and social and economic status); admission status (voluntary versus involuntary); Five Axis diagnoses; compliance of prescribed types of medications (antidepressants, antipsychotics, etc.); number of days admitted; number of admissions during the time period of the study; attendance and participation as documented on group therapy progress notes; topics presented in the group therapy sessions; and the credentials of the mental health providers leading the group therapy sessions.

Findings

Research Question One

The first research question examined in this study was as follows: To what degree do the clinical characteristics of admission status, diagnosis, medications, previous psychiatric inpatient admissions, and number of days admitted predict a patient's attendance in inpatient psychotherapy groups?

As hypothesized, there was a significant relationship between some clinical characteristics and patients' attendance in psychotherapy group treatment while psychiatrically hospitalized. The results of the stepwise regression equations indicated that three variables (medication compliance, prescription of anti-psychotic medications, and comorbid Axis I diagnoses) were predictors of inpatient group psychotherapy attendance. Patients who were not in compliance with their medications, who were on anti-psychotic medications, and who had comorbid diagnoses were less likely to attend inpatient group psychotherapy sessions. Each of the variables will be discussed next.

Medication management for stabilization is the primary intervention given to patients when admitted to the psychiatric hospital. Patients are admitted to an inpatient psychiatric facility for short term acute care when they are deemed a danger to self or others (suicidal or homicidal) or are unable to care for themselves due to psychosis or diminished capacity. The results of this study indicated patients who were compliant with psychotropic medications prescribed by psychiatrists while admitted to the hospital were more likely to attend psychotherapy groups offered. In addition, patients who were not prescribed antipsychotic medications and were not diagnosed with more than one Axis I diagnosis were also more likely to attend psychotherapy groups.

The necessity and effectiveness of antipsychotic medications for the treatment and control of symptoms in patients diagnosed with psychotic disorders (e.g., Schizophrenia and Bipolar disorder) is well documented in the literature (Liu-Seifert et al., 2007; Oehl et al., 2000). It is estimated that 50% of patients diagnosed with Schizophrenia are non-compliant with therapeutic interventions to include compliance with medications. The lack of compliance with medications usually leads to poor treatment outcomes and high rates of readmissions to psychiatric hospitals for stabilization (Perkins, 2002; Weiden & Olfson, 1995). It has been suggested patients diagnosed with Schizophrenia show resistance to taking antipsychotic medications due to stigma, adverse drug reactions, memory problems, and lack of social support (Hudson et al., 2004).

On the other hand, while the three factors (medication non-compliance, anti-psychotic medications, and comorbid Axis I diagnoses) predicted non-attendance, admission status, prior psychiatric inpatient admissions, and length of admission were not associated in predicting a patient's attendance in inpatient psychotherapy groups. Additional characteristics of patients that were not associated with their attendance in psychotherapy groups while hospitalized: age, marital status, ethnicity, gender, socio-economic status, suicidal ideation, homicidal ideation, psychosis, diminished capacity, number of readmits, Five Axis diagnoses, Global Assessment of Functioning (GAF) intake, GAF discharge, substance abuse history, anti-depressant medications, anti-anxiety medications, mood stabilizer medications, sedative medications, psycho-stimulant medications, and hypnotic medications.

In the case of admission status, patients are admitted to a psychiatric hospital either voluntary or involuntary. That fact is important because it may help explain a

patients' motivation to attend psychotherapy groups after admission based on his or her admission status. In the sample of patients for this study, 55.5% were admitted voluntarily and 44.5% were admitted involuntarily. Patients may be admitted involuntarily due to diminished capacity or inability to care for themselves. Patients may also be admitted involuntarily due to demonstrating imminent danger to themselves (suicide attempt or stated plan with intent) or others (homicidal attempt or intent) if they refuse voluntary inpatient treatment (Compton, & Craw, 2006).

However, patients' motivation to enter the hospital is not necessarily indicative of their compliance with treatment once admitted. Patients often have multiple contributing factors that surround their decision to voluntarily seek inpatient psychiatric care. These factors may include financial obligations, family responsibilities, and possible negative employment ramifications. Although the patient may have been admitted involuntarily, his or her motivation to decrease symptomology and resume previous responsibilities incites treatment compliance to include attendance of offered psychotherapy groups. Therefore, admission status was not shown to be a predictor of group psychotherapy attendance.

Similarly, a history of prior inpatient admissions does not necessarily predict a patient's lack of motivation to participate in treatment interventions, including psychotherapy group, while admitted to a psychiatric hospital. There are three possible reasons for this, namely, community treatment non-compliance, denial of the severity of mental illness, and lack of family support. This is perhaps due to the fact the patients often do not comply with community treatment options (medication management, counseling, case management, etc.) due to other reason, such as finances, transportation,

concern about stigma, denial of the severity of his or her mental illness, and a lack of family or social supports. Once a patient is admitted to an inpatient facility, he or she may be compliant with attending psychotherapy groups due to motivation to increase social supports (Vaughn et al., 1995) and learn coping skills to avoid future admissions (Blake et al., 1990; Dacey, 1989).

A final factor to consider that did not predict attendance is a patients' length of stay at the psychiatric hospital. Patients admitted to a psychiatric hospital have an average length of stay between 7 to 12 days, or until they can be safely treated at a lower level of care (e.g., outpatient treatment, partial inpatient treatment, or case management) and safely maintain in the community (Compton, Craw, & Rudisch, 2006). In this study, the average length of stay for patients was 6.45 days, the average number of groups offered was 6.1, and the average number of groups attended was 3.33. On average, patients attended half of the groups offered while admitted. A particular factor in the beginning and ending of their stay not being a predictor may be important in attendance. The study revealed that many patients did not attend psychotherapy groups offered the first and last day of their admission, which may account for length of stay not being a predictor of group attendance.

In summary, three factors (medication non-compliance, anti-psychotic medications, and comorbid Axis I diagnoses) predicted non-attendance. However, admission status, prior psychiatric inpatient admissions, and length of admission were not associated in predicting a patient's attendance in inpatient psychotherapy groups. Other patient characteristics found not to be associated with attendance in psychotherapy groups included: age, marital status, ethnicity, gender, socio-economic status, suicidal

ideation, homicidal ideation, psychosis, diminished capacity, number of readmits, Five Axis diagnoses, Global Assessment of Functioning (GAF) intake, GAF discharge, substance abuse history, anti-depressant medications, anti-anxiety medications, mood stabilizer medications, sedative medications, psycho-stimulant medications, and hypnotic medications.

Research Question Two

The second research question examined in this study was as follows: To what degree do the following variables of admission status, diagnosis, medications, previous psychiatric inpatient admissions, and number of days admitted predict a patient's participation in inpatient psychotherapy groups?"

As hypothesized, there was a significant relationship between clinical characteristics and patients' participation in psychotherapy group treatment while psychiatrically hospitalized. The results after conducting stepwise regression equations indicated that three variables (medication compliance, prescription of anti-psychotic medications, and comorbid Axis I diagnoses) were predictors of inpatient group psychotherapy participation. Patients who were compliant with psychotropic medications prescribed by psychiatrists while admitted to the hospital were more likely to participate in psychotherapy groups offered. In addition, patients who were not diagnosed with more than one Axis I diagnosis and were not prescribed antipsychotic medication and were more likely to participate in psychotherapy groups offered.

It could be speculated that patients do not participate in psychotherapy groups offered while admitted to a psychiatric hospital for the same reasons they do not attend. The reason may be that they are operating at a lower level of functioning than the average

patient. Patients admitted due to medication non-compliance, requiring antipsychotic medications for stabilization and clear thought processes, and diagnosed with multiple Axis I diagnoses are severely impaired. This level of impairment would prevent them from engaging in thought provoking and insightful group psychotherapy topics prior to increasing their level of functioning.

The following characteristics of patients were not associated with their attendance in psychotherapy groups while hospitalized: age, marital status, ethnicity, gender, socio-economic status, suicidal ideation, homicidal ideation, psychosis, diminished capacity, length of admission, number of readmits, history of prior admissions, Five Axis diagnoses, Global Assessment of Functioning (GAF) intake, GAF discharge, substance abuse history, anti-depressant medications, anti-anxiety medications, mood stabilizer medications, sedative medications, psycho-stimulant medications, and hypnotic medications.

Predictors of group psychotherapy participation were consistent with that of group psychotherapy attendance, showing the relationship between group attendance and participation. In this study, 45.8% did not attend groups offered. Of the remaining patients who chose to attend group, 74% actively participated. If patients chose to attend group sessions, then they also chose to participate. The three factors not predictive of group psychotherapy attendance, were also the same three factors not predictive of group psychotherapy participation.

Lazell (1921) advocated for the use of group therapy in the treatment of patients diagnosed with schizophrenia for the benefits of improving social functioning, reducing anxiety, increasing self-esteem, and decreasing recidivism (Kibel, 1992). However, if

patients are not attending and participating in psychotherapy groups offered, then perhaps other interventions should be considered to provide the same or similar benefits.

Research Question Three

The third research question examined in this study was as follows: To what degree do group psychotherapy facilitator credentials predict patients' participation or attendance in inpatient psychotherapy groups?

As hypothesized there was a significant relationship between the group psychotherapy facilitator credentials and patients' participation and attendance in psychotherapy group treatment while psychiatrically hospitalized. The results after conducting a Pearson Chi-Square test showed that inpatient group psychotherapy attendance was associated with the credentials of the facilitator. Patients attended more groups than expected that were facilitated by clinicians with a Master in Social Work (MSW) and attended less groups than expected for facilitators with Master of Arts (MA), Licensed Professional Counselor (LPC), and Licensed Clinical Social Worker (LCSW).

A clinician with an MSW has a master's degree in social work, but is not yet licensed. Perhaps beginning clinicians such as MSWs have more contact with patients and, as a result, patients are more likely to attend groups they convene. It is possible that contemporary MSW programs are effectively preparing graduates to provide inpatient services, and they are better equipped to encourage patients to attend groups they facilitate.

A Pearson Chi-Square test also indicated that there was a significant relationship between leader credentials and participation. Patients were more engaged than expected

in psychotherapy groups facilitated by clinicians with a MSW and LCSW and less engaged than expected in psychotherapy groups with MA and LPC facilitators.

MSWs and LCSWs are social workers, while MAs and LPCs are counselors. It is possible that social work programs are preparing graduates to engage psychiatric patients in group process more effectively than is being done in counselor preparation programs. Since counselors become group facilitators in psychiatric inpatient facilities, it is important that they be prepared to facilitate such groups in an effective manner, which would include finding ways to motivate patients to participate.

Research Question Four

The final research question examined in this study was as follows: To what degree do the topics presented in the group psychotherapy session predict a patient's participation or attendance in inpatient psychotherapy groups?

The hypothesis for Q4 was that there was a significant relationship between the topics presented in the group psychotherapy session and a patient's participation and attendance in psychotherapy group treatment while psychiatrically hospitalized. The results of the study did not offer support for this hypothesis. The results indicated that there was no significant relationship between topics presented and patients' attendance or participation in psychotherapy groups.

The fact that there was no significant relationship between the topic presented in group psychotherapy and patients' attendance and participation may be understandable. Patients were not informed in advance of the topics that would be presented in psychotherapy groups. The topic was presented after the group members had arrived and typically started as a check-in with patients (as documented in many of the group

psychotherapy notes). Perhaps in a different inpatient facility, group topics might be announced to patients in advance in an effort to encourage attendance.

It appears that when topics of groups are not announced, the topic of the group will not have an effect on participation. On the other hand, it would seem that patients would participate more or less depending on the topic of groups. However, in this study, that was not found to be the case. The topic of the groups had no effect on patients' participation once they were attending a group. From the results of this study, it appears that other factors, such as clinical conditions of patients and credentials of clinicians have an impact on patient participation, while the topic of the group does not.

Limitations of the Research Study

One limitation of this study was the ability to ensure external validity. External validity is defined by how generalizable the results of the research study can be applied to the population (Marczyk et al., 2005). Creswell (2009) stated that external validity threats "arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and past or future situations" (p. 162). This type of validity threat may be a problem due to characteristics of the participants, timing of the experiment, and uniqueness of setting. The interaction of the setting and treatment may be an issue in this study. Characteristics of the participants may prevent the results from being generalized to individuals in other settings.

The data for this study was collected in one private psychiatric hospital setting. Generalizing the results to other private or public hospitals should be done with caution.

Certain limitations were inherent to this study due to the use of historical data. In the data collection process the existing data was used. I had no control over the setting or

the instrumentation. The sample was taken from a specific population from one private inpatient psychiatric hospital. The results may be able to be generalized, however only to private psychiatric hospitals with similar patients. Therefore, generalizability of the results of this study may be limited.

Internal validity threats existed because the data were archival. Extraneous factors could not be controlled for by the researcher. Progress notes, intake and discharge summaries, and nursing assessments were conducted by various clinicians, physicians, and nurses and can be subjective in nature. I did not have control over the documentation process or consistency used when reporting on patients' behaviors and dynamic clinical characteristics.

Implications for Practice

Mental health professionals may find the results of this study to have beneficial implications. The three predictors of inpatient psychotherapy group attendance and participation were compliance with medications, antipsychotic medications, and comorbid Axis I diagnosis. Individuals with the clinical characteristics of being non-complaint with medications, having been prescribed antipsychotic medications, and having comorbid Axis I diagnoses are severely mentally ill upon admission. Based on the results of this study, there is a strong likelihood that these patients will not attend or participate in the group psychotherapy sessions offered and therefore this intervention will be of no benefit. Group psychotherapy does not work for these patients and alternative therapeutic interventions may need to be explored.

This study offers mental health professionals insight into patients' motivation to attend psychotherapy groups and identifies those who may not attend or benefit from the

intervention. Mental health professionals could create and offer these patients alternative interventions and strive to make inpatient treatment interventions more patient-centered versus a traditional group psychotherapy approach. Optimal interventions might include a Cognitive Behavioral Therapy (CBT) theoretical orientation behavior training approach to focus on increasing education (e.g., medication management and support), social skills, and coping skills. Problem solving approaches are empirically validated and are able to make a strong impact in a short amount of time (Sautter, Heaney, & O'Neill 1991) and should be considered as an approach for lower functioning patients. Interventions can be created and offered in group and individual formats by mental health professionals. Mental health professionals might consider creating highly structured (Yalom 1983) psycho-educational programs for patients who do not attend psychotherapy groups. Structured CBT groups or individual interventions could also be facilitated by unlicensed master's level paraprofessionals (MA or MSW) with supervision from mental health professionals, providing a therapeutic and cost effective option.

Group sessions of any kind might not be sufficient for patients who are severely impaired. Perhaps those in charge of the care of patients who are hospitalized need to seek alternatives to group sessions for severely mentally ill patients. Alternative treatments counselors might consider include individual psychotherapy, crafts, exercise, or other activities that would stimulate patients.

Alternative treatment options may be essential in the improvement of patients who are not attending inpatient psychotherapy groups. Data collected for the study indicated in some of the documentation from group psychotherapy progress notes that some alternative treatment options were actually offered. It was sometimes noted that

patients were offered handouts from the psychotherapy group missed or they were offered the option of an individual session. However, in the charts reviewed for this study, there were very few documented instances where a patient accepted the offer for an individual session with the facilitator.

Implications for Future Research

Researchers have confirmed to the overall effectiveness of groups (Kösters et al., 2006; Page & Hooke, 2009). However, no specific evidence has been provided to identify specific group interventions that are effective with different types of patients, ranging from the mildly impaired to the severely chronically mentally ill (Rose & Tollman, 1994).

Upon examination of the literature, there is a large gap in the scholarly research focused on characteristics of patients who attend and engage in inpatient group therapy. Due to decreased availability of beds and shortened length of stay in psychiatric inpatient facilities, it is important to maximize the therapeutic benefit to the patient while admitted to help decrease recidivism. This study contributed to the limited literature in the mental health field regarding inpatient group therapy and hopefully will stimulate additional research studies on this topic.

Future quantitative and qualitative studies are needed to examine alternative interventions to group psychotherapy for patients who refuse or who are too psychologically impaired to attend and participate. Perhaps another study of interest would be to interview patients who attend inpatient psychotherapy groups although he or she may exhibit one or all of the predictors of non-attendance.

Conclusion

Inpatient psychiatric hospitals have evolved from long-term psychiatric care to short-term acute psychiatric crisis interventions (Baker & Geise, 1992; Springer & Silk, 1996; Vaughn et al., 1995). Patients are admitted to psychiatric hospitals and typically stay an average length of between 7 to 12 days, or until they can be safely treated at a lower level of care (e.g., outpatient treatment or partial inpatient treatment) and safely maintain in the community (Compton, Craw, & Rudisch, 2006). While a patient is admitted to a psychiatric facility, the primary focus is placed on medication management (Yalom, 1983). Individual psychotherapy is typically not offered for each patient (Santa Ana et al., 2007) due to the number of patients, so group psychotherapy is utilized for the therapeutic benefits and the resource effectiveness.

The results of this study suggest that not all patients are benefitting from group psychotherapy while admitted to an inpatient hospital. This study determined that three clinical characteristics (medication compliance, antipsychotic medications, and comorbid Axis I diagnoses) predict a patients' attendance and participation in psychotherapy groups. The ability to identify patients who are more likely not to attend group enables mental health professionals to create additional interventions to achieve similar results and decrease recidivism. Further studies are needed to examine alternative interventions for patients who refuse or are too psychologically impaired to attend and participate in inpatient group psychotherapy sessions traditionally offered.

CHAPTER SIX

MANUSCRIPT

INPATIENT PSYCHOTHERAPY GROUPS:

PREDICTING ATTENDANCE AND PARTICIPATION

Sharon E. Silverberg

Theodore P. Remley, Jr.

Renee Seay

Old Dominion University

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ABSTRACT

Group psychotherapy is the primary talk therapy offered to patients admitted to an inpatient psychiatric hospital. Research has shown group psychotherapy attendance and participation increases patients' likelihood of success post discharge and decreases recidivism. Not all patients admitted to psychiatric hospitals choose to attend group psychotherapy sessions offered and therefore do not benefit. This article offers an analysis of the predictors of inpatient group psychotherapy attendance and participation, provides future research directions, and considers implications for mental health professionals serving this population.

Key Words: Inpatient Treatment, Group Psychotherapy

INTRODUCTION

Group psychotherapy began after World War I in the 1920's in North America. It was at this time that Edward L. Lazell began working with war veterans diagnosed with schizophrenia at St. Elizabeth's Hospital in Washington, D.C. Lazell (1921) stated that group psychotherapy assisted patients with increased socialization and decreased fears regarding the therapist. In 1931, L. Cody Marsh worked with groups of patients hospitalized in Massachusetts utilizing group exercises and activities to help patients with their rehabilitation (Kibel, 1992). In 1983, Irvin Yalom developed a method of inpatient group therapy at Stanford University. Yalom's focus on inpatient psychotherapy was based around a dynamic approach to a patient's interpersonal learning with special attention to the "here and now".

Group psychotherapy has been shown to be an effective treatment invention for patients suffering from psychiatric illness including Mood Disorders (Burlingame & Barlow, 1996; Kuhns, 1997; Murphy, 1997; McNamee et al., 1995; Scott & Stradling, 1990), Obsessive-Compulsive Disorder (Van Noppen et al., 1998), Social Phobias (Fanget, 2000; Heimberg et al., 1998; Hope et al.; 1995; Scholing & Emmelkamp, 1993), and Eating Disorders (Davis et al., 1990; Davis et al., 1997; Hartmann et al., 1992; Mitchell et al., 1993; Peterson et al., 1998).

Group psychotherapy integrates both the interpersonal and interactional climate established and maintained by the group itself (Lambert, 2004). It also creates a sense of value for the patient on the group as the mode for which change will occur and the group member's interactions the primary delivery of the change in members who participate (Furhiman & Burlingame, 1990). After decades of research, group psychotherapy

treatment has shown to be effective even as a sole intervention for some patients suffering from psychiatric illness (Fuhriman & Burlingame, 1994).

Over the last several decades, inpatient psychiatric hospitals have evolved from long term psychiatric care to short term acute psychiatric treatment (Baker & Geise, 1992; Springer & Silk, 1996; Vaughn et al., 1995). Currently in the United States, individuals admitted to a psychiatric hospital typically stay an average length of between 7 to 12 days, or until they can be safely treated at a lower level of care (e.g., outpatient treatment or partial inpatient treatment) and safely maintain in the community (Compton, Craw, & Rudisch, 2006). While a patient is admitted to a psychiatric facility, the primary focus is placed on medication management (Yalom, 1983). Since psychopharmacology is the primary therapeutic focus for psychiatric patients, not psychotherapy, and in combination with the large number of patients admitted to a psychiatric hospital at any given time, individual psychotherapy is typically not offered for each patient (Santa Ana et al., 2007).

Group psychotherapy is the primary talk therapy offered to patients while admitted to a psychiatric inpatient facility (Farley, 1998; Strauss & Burgmeier-Lohse, 1994; Tschuschke, 2004; Weiss, 2010; Yalom, 1983). Inpatient group psychotherapy has been shown to be effective and makes efficient use of the patients' time and the hospital and staff's resources (Yalom, 1983; Kösters et al., 2006). Research has proven that it is beneficial for patient outcomes post discharge if they participate in group psychotherapy while admitted to a psychiatric hospital (Page & Hooke, 2009).

Not all patients chose to attend group psychotherapy sessions offered while admitted to the psychiatric facility and therefore do not benefit. This lack of participation

in group psychotherapy deprives the patient the opportunity to share thoughts and feelings related to the stressors and issues leading to the psychiatric inpatient admission (Vaughn et al., 1995). It also denies them of the chance to receive additional support in learning coping skills to better deal with stressors in the future, thereby possibly preventing additional psychiatric inpatient hospitalizations (Blake et al., 1990; Dacey, 1989).

Group psychotherapy plays a large role in patients' recovery while admitted to a psychiatric hospital and his or her success upon discharge (Page & Hooke, 2009). Therefore, it is important to understand what clinical factors contribute to patients' participation and attendance of inpatient group psychotherapy. The ability to predict patients' attendance and participation in inpatient group psychotherapy will help mental health professionals identify those who may need additional support and encouragement to attend. It has been suggested that behavioral strategies, such as verbal instructions and feedback, have been studied and shown to significantly increase patient's attendance in inpatient group therapy (Blake, Owens, & Keene, 1990). This assistance may increase the likelihood of the patients attending psychotherapy groups while admitted to the hospital, even as early as the first day. Moreover, it may also increase the likelihood of success upon discharge into the community to a lower level of care and decrease the rate in inpatient psychiatric admission recidivism (Page & Hooke, 2009).

The purpose of this study was to examine predictive factors contributing to a patient's attendance and participation of inpatient psychotherapy groups by utilizing historical data. Data analyzed included demographic information (gender, race, age, ethnicity, and SES); admission status (voluntary versus involuntary); DSM-IV TR

diagnosis (Axis I, II, III, IV, and IV); compliance of current prescribed types of medications (antidepressants, antipsychotics, etc.); number of days admitted, number of admissions during the time period of the study (one year); attendance and participation as documented by hospital staff on group therapy progress notes; topics presented in the group therapy sessions; and the credentials of the mental health providers leading the group therapy sessions.

This study identified characteristics in patients that lead to non-attendance or non participation in group therapy while admitted to the psychiatric facility. The results of this study may increase the ability of mental health professionals to engage patients who may have characteristics predictive of not attending or participating in group therapy. Increasing attendance and participation in inpatient group therapy sessions may help to provide a positive outcome for a patient's future success in the community.

METHOD

Participants in this study were patients randomly selected from a data base of approximately 2,000 patients, ranging in age from 18-65, admitted to a private psychiatric hospital located in the mid-Atlantic section of the United States from June 2009 to May 2010. Of the 2,000 patients, 150 were selected using a random number generator. According to Cohen (1992), assuming a moderate effect size at the p=.80 level, a minimum sample of 107 patients were needed to have adequate power for hypotheses that are tested at the .05 alpha level. In order to strengthen the study, 150 patients were utilized in the data collection process.

The sample was comprised of 61 (40.7%) males and 89 (59.3%) females. Patients represented the following ethnicities: 103 (68.7%) Caucasian, 38 (25.5%) African

American, 7 (4.7%) Hispanic, and 2 (1.3%) Asian. Funding for inpatient treatment was 123 (82%) insured patients and uninsured 27 (18%) (see Table 1).

Data were collected over a period of six weeks onsite at the psychiatric hospital. Each physical chart was thoroughly reviewed for specific clinical information documented by clinical and paraprofessional staff, including intake reports, discharge summaries, physician reports, medication administration documentation, and individual group psychotherapy progress notes.

The study was a correlational design used to predict group attendance and participation from several individual difference variables. Data was analyzed by using SPSS (version 17) software. Frequency distributions were utilized to report data such as gender, age, race/ethnicity, diagnosis, admission status, prescriptions taken during admission, and number of group therapy sessions offered, attendance, and quality of attendance. Correlations were completed to examine the significant relationships between demographic variables and the predictor variables. Regressions were used to test the hypothesis. Demographic variables found to be significantly related to any predicted or outcome variable were included in the regression.

RESULTS

As hypothesized, there was a significant relationship between some clinical characteristics and patients' participation in psychotherapy group treatment while psychiatrically hospitalized (see table 2). The results of the stepwise regression equations indicated three variables (medication compliance, prescription of anti-psychotic medications, and comorbid Axis I diagnoses) were predictors of inpatient group psychotherapy attendance. Patients who were not in compliance with their medications,

who were on anti-psychotic medications, and who had comorbid diagnoses were less likely to attend inpatient group psychotherapy sessions. The patient characteristics of admission status, previous psychiatric inpatient admissions, and number of days admitted did not predict a patient's attendance in inpatient psychotherapy groups.

Patients are admitted to an inpatient psychiatric facility for short term acute care when they are deemed a danger to self or others (suicidal or homicidal) or are unable to care for themselves due to psychosis or diminished capacity. Medication management for stabilization is the primary intervention given to patients when admitted to the psychiatric hospital. The results of this study indicated patients who were compliant with psychotropic medications prescribed by psychiatrists while admitted to the hospital were more likely to attend psychotherapy groups offered. In addition, patients who were not prescribed antipsychotic medications and were not diagnosed with more than one Axis I diagnosis were also more likely to attend psychotherapy groups.

There was also a significant relationship between clinical characteristics and patients' participation in psychotherapy group treatment while psychiatrically hospitalized (see table 3). The results after conducting stepwise regression equations indicated three variables, medication compliance, prescription of anti-psychotic medications, and comorbid Axis I diagnoses were predictors of inpatient group psychotherapy participation. Patients who were compliant with psychotropic medications prescribed by psychiatrists while admitted to the hospital were more likely to participate in psychotherapy groups offered. In addition, patients who were not diagnosed with more than one Axis I diagnosis and were not prescribed antipsychotic medication and were more likely to participate in psychotherapy groups offered.

It could be speculated that patients do not participate in psychotherapy groups offered while admitted to a psychiatric hospital for the same reasons they do not attend. The reason may be that they are operating at a lower level of functioning than the average patient. Patients admitted due to medication non-compliance, requiring antipsychotic medications for stabilization and clear thought processes, and diagnosed with multiple Axis I diagnoses are severely impaired. This level of impairment would prevent them from engaging in thought provoking and insightful group psychotherapy topics prior to increasing their level of functioning.

The following characteristics of patients were not associated with their attendance in psychotherapy groups while hospitalized: age, marital status, ethnicity, gender, socio-economic status, suicidal ideation, homicidal ideation, psychosis, diminished capacity, length of admission, number of readmits, history of prior admissions, Five Axis diagnoses, Global Assessment of Functioning (GAF) intake, GAF discharge, substance abuse history, anti-depressant medications, anti-anxiety medications, mood stabilizer medications, sedative medications, psycho-stimulant medications, and hypnotic medications.

Predictors of group psychotherapy participation were consistent with that of group psychotherapy attendance, showing the relationship between group attendance and participation. In this study, 45.8% did not attend groups offered. Of the remaining patients who chose to attend group, 74% actively participated. If a patient chose to attend group then they also chose to participate. The factors not predictive of group psychotherapy attendance are, therefore, were also not predictive of group psychotherapy participation.

Analysis also indicated a significant relationship between the group psychotherapy facilitator credentials and patients' participation and attendance in psychotherapy group treatment while psychiatrically hospitalized. A Pearson Chi-Squares test showed that inpatient group psychotherapy attendance was associated with the credentials of the facilitator. Patients attended more groups than expected that were facilitated by clinicians with a Master in Social Work (MSW) and attended less groups than expected for facilitators with Master of Arts (MA), Licensed Professional Counselor (LPC), and Licensed Clinical Social Worker (LCSW).

A clinician with an MSW has a master's degree in social work, but is not yet licensed. Perhaps beginning clinicians such as MSWs have more contact with patients and, as a result, patients are more likely to attend groups they convene. It is possible that contemporary MSW programs are effectively preparing graduates to provide inpatient services, and they are better equipped to encourage patients to attend groups they facilitate.

A Pearson Chi-Square test also indicated that there was a significant relationship between leader credentials and participation. Patients were more engaged than expected in psychotherapy groups facilitated by clinicians with a MSW and LCSW and less engaged than expected in psychotherapy groups with MA and LPC facilitators.

MSWs and LCSWs are social workers, while MAs and LPCs are counselors. It is possible that social work programs are preparing graduates to engage psychiatric patients in group process more effectively than is being done in counselor preparation programs. Since counselors become group facilitators in psychiatric inpatient facilities, it is

important that they be prepared to facilitate such groups in an effective manner, which would include finding ways to motivate patients to participate.

The final question addressed in the study was if there was a significant relationship between the topics presented in the group psychotherapy session and a patient's participation and attendance in psychotherapy group treatment while psychiatrically hospitalized. However, the results of the study indicated that there was no significant relationship between topics presented and patients' attendance or participation in psychotherapy groups.

The fact that there was no significant relationship between the topic presented in group psychotherapy and patients' attendance and participation was understandable. Patients were not informed in advance of the topics that would be presented in psychotherapy groups. The topic was presented after the group members had arrived and typically started as a check-in with patients (as documented in many of the group psychotherapy notes). Perhaps in a different inpatient facility, group topics might be announced to patients in advance in an effort to encourage attendance.

Obviously when topics of groups are not announced, the topic of the group will not have an effect on participation. On the other hand, it would seem that patients would participate more or less depending on the topic of groups. However, in this study, that was not found to be the case. The topic of the groups had no effect on patients' participation once they were attending a group. From the results of this study, it appears that other factors, such as clinical conditions of patients and credentials of clinicians have an impact on patient participation, while the topic of the group does not.

DISCUSSION

The results of this study suggest that not all patients are benefitting from psychotherapy while admitted to an inpatient hospital. This study determined that three clinical characteristics (medication compliance, antipsychotic medications, and comorbid Axis I diagnoses) predict a patients' attendance and participation in psychotherapy groups. The ability to identify patients who are more likely not to attend group enables mental health professionals to create additional interventions to achieve similar results and decrease recidivism.

The results of this study offers mental health professionals insight into patients' motivation to attend psychotherapy groups and identify those who may not attend or benefit from the intervention. Additionally, mental health professionals could create and offer these patients alternative interventions and strive to make inpatient treatment interventions more patient-centered versus a traditional group psychotherapy approach. Optimal interventions might include a Cognitive Behavioral Therapy (CBT) theoretical orientation behavior training approach to focus on increasing education (e.g., medication management and support), social skills, and coping skills. Problem solving approaches are empirically validated and are able to make a strong impact in a short amount of time (Sautter, Heaney, & O'Neill 1991). Interventions can be created and offered in group and individual formats by mental health professionals. Mental health professionals might consider creating highly structured (Yalom 1983) psycho-educational programs for patients who do not attend psychotherapy groups. Structured CBT groups or individual interventions could also be facilitated by unlicensed master's level paraprofessionals with

supervision from mental health professionals, providing a therapeutic and cost effective option.

Perhaps those in charge of the care of patients who are hospitalized need to seek alternatives to group sessions for severely mentally ill patients. Alternative treatments might include individual psychotherapy, crafts, exercise, or other activities that would stimulate patients.

Data collected for the study indicated in some of the documentation from group psychotherapy progress notes that some alternative treatment options were offered. It was sometimes noted that patients were offered handouts from the psychotherapy group missed or they were offered the option of an individual session. However, in the charts reviewed for this study, there were very few documented instances where a patient accepted the offer for an individual session with the facilitator.

Upon examination of the literature, there is a large gap in the scholarly research focused on characteristics of patients who attend and engage in inpatient group therapy. Due to decreased availability of beds and shortened length of stay in psychiatric inpatient facilities, it is important to maximize the therapeutic benefit to the patient while admitted to help decrease recidivism.

IMPLICATIONS

Mental health professionals may find the results of this study to have beneficial implications. The three predictors of inpatient psychotherapy group attendance and participation were compliance with medications, antipsychotic medications, and comorbid Axis I diagnosis. Individuals with clinical characteristics including non-complaint with medications, prescribed antipsychotic medications, and have comorbid

Axis I diagnoses is indicative of a patient severely mentally ill upon admission. Based on the results of this study, there is a strong likelihood that these patients will not attend or participate in the group psychotherapy sessions offered and therefore this intervention will be of no benefit. Group psychotherapy does not work for these patients.

This study contributed to the limited literature in the mental health field regarding inpatient group therapy and hopefully will stimulate additional research studies on this topic.

The outcome of this study suggests further studies are needed to examine alternative interventions for patients who refuse or are too psychologically impaired to attend and participate in inpatient group psychotherapy sessions traditionally offered. Future studies are needed to examine alternative interventions to group psychotherapy for patients who refuse or are too psychologically impaired to attend and participate.

Table 1
Descriptive Demographic Characteristics

Characteristics	Number (Percent)
N	150
Age	
Range	18-65
Mean Age	37.45
Gender	
Male	61 (40.7%)
Female	89 (59.3%)
Ethnicity	
Caucasian	103 (68.7%)
African American	38 (25.5%)
Hispanic	7 (4.7%)
Asian	2 (1.3%)
SES	
Insured	123 (82%)
Uninsured	27 (18%)
Marital Status	
Single	81 (54%)
Married	52 (34.7%)
Divorced	13 (8.7%)
Widowed	4 (2.7%)

Table 2

Predicting Percentage of Attendance in Psychotherapy Groups by Clinical Characteristics

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	Not Medication Compliant	-.361	.107	-.269	-3.384	.001
2	Not Medication Compliant	-.331	.106	-.246	-3.120	.002
	Prescribed Anti-Psychotic Medicines	-.124	.053	-.184	-2.333	.021
3	Not Medication Compliant	-.342	.105	-.255	-3.275	.001
	Prescribed Anti-Psychotic Medicines	-.140	.053	-.207	-2.649	.009
	Co-morbid Diagnoses	-.118	.050	-.183	-2.350	.020

Table 3

Predicting Percentage of Participation in Psychotherapy Groups by Clinical Characteristics

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	Prescribed Anti-Psychotic Medications	-.505	.153	-.263	-3.308	.001
2	Prescribed Anti-Psychotic	-.452	.150	-.236	-3.008	.003
	Not Medication Compliant	-.856	.299	-.224	-2.859	.005
3	Prescribed Anti-Psychotic	-.493	.150	-.257	-3.288	.001
	Not Medication Compliant	-.885	.296	-.232	-2.988	.003
	Comorbid Diagnoses	-.299	.142	-.164	-2.108	.037

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APPENDIX

HUMAN SUBJECTS COMMITTEE APPROVAL

OLD DOMINION UNIVERSITY
DARDEN COLLEGE OF EDUCATION
OFFICE OF THE DEAN
NORFOLK, VIRGINIA 23529-0156
PHONE: (757) 683-3938
FAX: (757) 683-5183

May 13, 2010 Proposal Number __200902129__

Professor Remley:

Your proposal submission titled, "**Inpatient Psychotherapy Groups: Predicting Attendance and Participation**" has been deemed EXEMPT by the Human Subjects Review Committee of the Darden College of Education. If any changes occur, especially methodological, notify the Chair of the DCOE HSRC, and supply any required addenda requested of you by the Chair. You may begin your research.

We have approved your request to pursue this proposal indefinitely, provided no modifications occur. Also note that if you are funded externally for this project in the future, you will likely have to submit to the University IRB for their approval as well.

PRIOR TO THE START OF YOUR STUDY, **you must send a signed and dated hardcopy of your exemption application submission to the address below.**
Thank you.

Edwin Gómez, Ph.D.
Associate Professor
Chair, Human Subjects Review Committee, DCOE
Human Movement Studies Department
Old Dominion University
2010 Student Recreation Center
Norfolk, VA 23529-0196
757-683-6309 (ph)
757-683-4270 (fx)

CURRICULUM VITAE

Sharon E. Silverberg earned a Bachelor of Science degree in Biology and a Bachelor of Science degree Psychology in 1998 from Old Dominion University and a Master of Arts degree in Community Psychology from The University of New Haven in 2003. She is a licensed professional counselor, licensed marriage and family therapist, national certified counselor, certified sex offender treatment provider, and registered play therapist supervisor.

Ms. Silverberg is an editorial review board member of the *Arizona Counseling Journal*. She has presented and co-presented at national, regional, and state level conferences on a variety of subjects, including mental status exams, play therapy, and trauma.

Ms. Silverberg has provided therapeutic and clinical services for clients ranging from the mildly impaired to the severely chronically mentally ill in a variety of settings including inpatient, outpatient, residential, and in-home.

Ms. Silverberg is an active member of several national professional organizations including the American Counseling Association (ACA), the Association for Play Therapy (APT), and the Association for Counselor Education and Supervision (ACES).