A Psychotherapeutic Approach to Task-Oriented Groups of Severely Ill Patients

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This paper presents a conceptual approach for leading various types of groups of chronically mentally ill patients. Although these groups may have a concrete, task-oriented purpose, with skillful leadership they also function as psychotherapy groups. The developmental deficits in ego functions, object relations, and social skills that severely impair such groups can be compensated by non-interpretative actions of the therapists. The group leader must actively work to provide for the structure, stability, and safety of the group when group members are unable to provide these for themselves.

Groups of various kinds have become a vital element in the comprehensive treatment of severely ill psychiatric patients, both within hospitals and in community settings [1–2]. Such groups have the potential of supplying precisely the sort of human contact which is so tragically missing from the lives of these patients [3–5]. Although such groups may meet expressly for psychotherapy, more often groups have a concrete focus such as cooking, athletics, assertiveness training, or medication supervision. It has been demonstrated that, with skillful leadership, such focused groups not only can attend to the concrete task but also can foster more generalized psychotherapeutic processes [6, 7].

Many therapists are unsure how to go about the difficult task of paying attention to the dynamic processes of the group as well as to the concrete goals. In practice, much of the theory developed for use with psychotherapy groups is directly applicable to other kinds of groups of the severely ill. The many technical difficulties inherent in leading psychotherapy groups with severely ill patients have been addressed in the literature [8–12]. A number of authors have suggested techniques to deal with special problems arising in these groups [13–16]. Yalom’s book, \textit{Inpatient Group Psychotherapy}, is a major new contribution to this field [17]. This paper, using these ideas as a foundation, presents for therapists working with this population a simple but generalized theoretical and technical framework that is useful in a variety of group settings.

Even while attending to the concrete tasks of the group, therapists can be deeply involved in the dynamic processes of the group. These patients can be approached as one would neurotic outpatients [18], except that the therapist must actively intervene to counter the effects of specific developmental deficits that hinder the function of groups of severely ill patients. These deficits fall into three categories: (1) poorly structured ego functions, (2) primitive object relations, and (3) poor social skills. The
therapist can compensate for these deficits through direct, non-interpretative actions, essentially by "supplying what's missing."

"Supplying what is missing" is an idea elaborated by Robin Skynner [19] in his work with both families and groups. Skynner viewed groups as "struck" because of "missing" affects due to developmental failures. These deficits must be compensated for if the group is to deal productively with its problems. Skynner sought to provide these avoided and denied affects through real actions and feelings of the therapist rather than through interpretation. The therapist presents these actions and feelings as his own but also suggests that they bear on the group process. Psychotic groups, however, have much more "missing" than just these affects. They have severe deficits in ego function, object relations, and social skills, but these deficits can also be compensated for by non-interpretative actions of the therapist. We will discuss each of these three large areas in turn. We will demonstrate this approach through clinical material drawn from our experience leading a weekly "medication group" in the day treatment unit of a community mental health center, which has been described elsewhere [20].

EGO DEFICITS

Kernberg [21] has described in detail the development ego deficits of severely impaired patients in a number of diagnostic categories. Despite differences in ego functioning, all of these patients show "non-specific ego weakness" in three broad ways: lack of anxiety tolerance, lack of impulse control, and lack of sublimatory channels. For group therapy to succeed with severely ill patients, attention to these ego deficits is essential. The therapist must intervene when there are general signs that ego weakness is impeding the group; that is, when anxiety is leading to disorganization, when patients act impulsively, and when patients have difficulty constructively channeling their emotions.

Anxiety Tolerance

In neurotic groups, anxiety largely serves a signal function, alerting patients to the unconscious importance of the emerging material and bringing into play their characteristic ego defenses. Group patients, as they explore their functioning in the group, become familiar with their defenses and later with the conflicts against which they have been defending. Because of their well-developed egos, neurotic patients are able to integrate this experience by giving up maladaptive defenses and resolving conflicts. The therapist's role is to maintain an atmosphere which supports this activity and to have faith in the patients' ability to utilize the experience productively.

Psychotic groups function quite differently. Anxiety, rather than serving a signal function that elicits defenses, often leads to ego fragmentation. Furthermore, patients are not free to explore their conflicts because, as they are painfully aware, they lack impulse control. Patients have worked hard for years to build effective defenses and have a realistic fear of what they might do if the defenses are lifted. Therefore, the therapist of a psychotic group must more actively help the patients to channel their anxiety than would be necessary or productive in a neurotic group.

Many useful interventions are directed toward increasing patients' self-observation, suggesting that anxiety can serve a signal function. For example, when anxiety is experienced by our patients as fragmentation, we ask, "What's it like for you when you start to get crazy?" "When you notice you're starting to get a little crazy, what can you
LEADING TASK-ORIENTED GROUPS OF THE SEVERELY ILL

do about it?" "How do others of you know when you’re getting crazy?" "Can you tell when you need more or less medicine?" "Besides taking medicine, what can you do to feel better when you’re getting crazy?" Patients learn to initiate these discussions on their own, at times allowing the group to operate with less input from the therapists and to appear more similar to a group of neurotic patients.

In neurotic groups, reality testing is impaired to the extent that patients experience paratactic distortions. The therapist helps the group recognize these distortions. In psychotic groups, reality testing is much more severely impaired. Patients are frequently hallucinating or delusional during the meetings. Consequently, it is important to take an active stance in encouraging the group to test reality. In our group we inquired about hallucinations and delusions and encourage discussion among the patients about the reality of their content, as well as about strategies of testing reality. We teach that perception is subjective but can be made more objective by checking with other people about their perceptions. We also encourage patients to test their impressions of interpersonal reality by asking other people what they think is going on: "Jim, you said Bob was mad at you. I can’t tell if he is or not. Could you check it out with him?"

In any group, frustration of dependency needs results in anxiety. In a neurotic group, dependency needs are gratified principally by other patients. The leader’s relative abstinence leads to patients discovering that they can fulfill each other’s needs, rather than habitually turning to the authority figure for nurturance. This discovery comes only after the group has experienced considerable anxiety. In a psychotic group, the degree of anxiety which would be generated by such abstinent leadership would be intolerable for the patients. Group process would cease as patients withdrew into themselves or physically left the group in an effort to guard against the very real danger of ego fragmentation and psychosis. So instead of the friendly but abstinent stance of the neurotic group’s leadership, therapists working with more severely ill patients must provide a more nurturant base for the group’s activity.

We labeled our group a “medication” group rather than a “therapy” group to make explicit the leadership’s underlying commitment to meeting the patients’ reality-based needs. During the group we write prescriptions, usually for a few weeks’ supply of medication. Immediately following the group we often dispense medications. Thus, patients need to see us frequently for replenishment of these supplies. We explain, time and again, that this is because we are interested in how the medications are affecting them. We want to know, and we want the group to know, how a patient’s medications are helpful and in what way they are causing problems. We want the patients to check in frequently with us and the group, so that we can work together to maximize the benefits of the medications. We use discussion about medications to promote group cohesiveness by actively involving the entire group in these discussions rather than limiting them to a dialogue between an individual patient and the psychiatrist. For example, when patients ask the group leader about a new medication or about a side effect, the question is redirected to the group. Usually, other patients in the group have already been on that medication or experienced that side effect, and can talk from a very different perspective than that of the psychiatrist. This procedure allows patients the chance to share their expertise and encourages group members to listen to each other. We sometimes make small adjustments in dosages that are responsive to the patients’ subjective needs, even if they are pharmacologically insignificant. This sort of attention to concrete needs with enthusiastic, careful monitoring of subjective effects
as well as frequent giving of needed supplies is an aspect of good mothering throughout the early years. By coupling medication checks with the supportive environment of the group, we invest the group with the symbolic qualities of the good mother and provide a real, nurturant foundation for all group process.

This nurturant foundation is reinforced by the therapists' careful attention to their own level of activity. As Balint [22] pointed out, when group leaders are too active, they stifle the productive efforts of their patients. On the other hand, when therapists are not active enough, patients feel lost as the group flounders. It is important for group leaders to titrate carefully the level of their own activity, constantly monitoring the group for signs that patients are feeling either intruded upon or abandoned. Intrusion and abandonment are two principal types of early mothering failure, and psychotic patients are profoundly sensitive to their effects. By modulating their activity level to avoid group feeling of intrusion and abandonment, therapists invest the group atmosphere with the safe yet stimulating qualities of "good enough" mothering [23].

Impulse Control

Because of poorly developed sublimatory channels, patients have few options for gratification other than direct expression of their impulses, which they know from experience gets them into trouble. Therapists with psychotic groups must be aware that patients' sterility and inactivity may be, therefore, highly developed, realistic, coping mechanisms. If these coping strategies are undermined without the therapists attending to the group's ego deficits, the result can be an increase in psychosis and impulsive action.

The following unfortunate example illustrates this process:

A middle-aged man with chronic paranoid schizophrenia had attended regularly for a number of months. Although he rarely spoke, he was accepted by the other patients and seemed to enjoy the sessions. When he did speak, it was to say that he sometimes felt that people were out to get him, but that "400 mg daily of Thorazine—no other drug or dose—made things better." One day, however, he spoke up, disagreeing with a woman over her ideas about medication. When she refused to change her opinion, he began to berate her. The therapists tried to calm him down and described how the patient's shouting made them feel, but they did nothing to set concrete limits. The man became increasingly loud, angry, and agitated. Other group patients were silent; several left the room. The woman whom he had criticised and a woman friend of hers burst into tears. The man left the room but continued his disruptive behavior in the commons area and was eventually evicted from the building for the day. The crying women and the other patients, although clearly upset, refused to talk about the incident. The remainder of the meeting was quiet but chaotic, with only trivial or matter-of-fact issues being raised, despite the therapists' attempts to discuss the effects of the incident.

For patients to feel safe in a psychotic group, it is essential that the therapists make it clear that patients' impulsive actions will be controlled, if not by the patients, then by the therapists. We have explicit rules prohibiting physical assault and abusive language. When a patient's impulses are getting out of hand, we point it out and give the patient an opportunity to control himself by whatever means he can: quieting down, leaving the room, or an individualized coping strategy. If the patient is unable to find a solution, we suggest one. If the suggestion is refused we will take whatever steps are
necessary to control the behavior, which in the extreme case could include physical or chemical restraint or emergency hospitalization. One drawback to this approach is that patients may feel that the therapists are overly controlling or sadistic, but this attitude can be discussed like any other and is far outweighed by the safety patients feel in knowing that their impulses, and those of the other patients, will be controlled when they themselves have lost control.

Sublimatory Channels

Chronically mentally ill patients lack sublimatory channels and need help achieving gratification when their immediate aims are unattainable. Humor, which is often a sublimated form of aggression, can be encouraged. Social activities can be used as a way to gain freedom from problems of living: “I know you’re frustrated by not knowing if you’ll get social security disability or not, but since you can’t do anything about it today anyway, going to the volleyball game might take your mind off things for a while.” Postponement of gratification can also be reinforced: “So what you’re saying is that you’d really like to move out of the County Home into your own apartment, but they won’t let you until you’ve kept yourself under control for a few months. I bet it’s hard for you to keep control, but it could be worth it, if it means you’d get your own apartment.”

Many patients tend not to verbalize their important concerns. Talking should be actively encouraged, to an extent that would be intrusive in a neurotic group, with comments like “Mary, you look sad. Can you talk about what you’re feeling?” Often patients are unable to verbalize feelings even with questioning. At that point the therapists, can express their own feelings and may suggest that their feelings have a bearing on the patient. For example, we may say, “Mary, somehow I’m feeling sad just sitting here talking to you.” This is accompanied by an invitation to respond, either implicitly in our tone, or explicitly with the addition of something like, “I wonder if you’re feeling sad, too.” The object is not to elicit affect, but to encourage the patients to experience and talk about difficult issues in safe, controlled ways. Verbalization is an important step in building an observing ego. It promotes use of secondary process and turns private, autistic thought into communication. Verbalization also decreases impulsivity by providing an alternative to instant action and giving the patient an opportunity to consider before acting.

Closely linked to the ability to sublimate instinctual impulses is the ability to soothe oneself. Most chronically mentally ill patients have poorly developed self-soothing mechanisms. One can provide these by first legitimating the concept of being good to oneself and then exploring what methods patients use to help themselves feel good: “What sorts of things can you do to get to feel good when you’re really upset?” “Have there been times when you’ve felt like cutting yourself but something else gave you relief?” “You know, most everyone here feels pretty down or upset sometimes. I bet they’ve got ways of getting better. It could be that something that works for one of them could work for you. You might consider asking them about it.” Again, patients learn to feel good themselves by learning how to help other patients feel good. Patients can often see options for someone else and later apply these same options to themselves.

Finally, patients can be encouraged to take pride in being able to tolerate the inevitable anxiety and pain which fill their lives. We tell our patients that we are well aware that they need much more than they are getting, that treatment cannot possibly give them what they deserve as people, and that we doctors admire them for their courage and stamina, which we do.
OBJECT RELATIONS

The second broad category of "what's missing" that one must consider is deficits in mature object relations. Severely ill patients lack truly intimate, consistent social relationships. Their relatedness to others is tenuous at best, and their view of themselves is equally unstable. As Kernberg [21] demonstrated, these tenuous social relationships can be understood as reflecting poorly developed intrapsychic object relations. For many patients, the salient developmental defect is the failure to integrate contradictory self and object images, accompanied by failure to move beyond the ego defense mechanisms of "splitting," and "projective identification," and diffusion of ego boundaries.

Splitting, the "active process of keeping apart introjections and identification of opposite quality," prevents diffusion of anxiety within the ego, protecting positive introjections and identifications from contamination with the "all bad" self and object images. Projective identification serves to externalize the "all bad" images but results in the patient experiencing others as dangerous, retaliatory objects against whom he must defend himself. Projective identification differs from neurotic projection in that the patient, because of weak ego boundaries, also identifies with the retaliatory object. The patient feels that he himself is cruel and dangerous.

Because splitting and projective identification are so prominent in psychotic groups, special techniques are required. In dealing with neurotic patients, therapists can be relatively anonymous and opaque, as neurotic patients have the capability of working through the transference distortions that this stance engenders. In psychotic groups, the therapist must present a more three-dimensional, differentiated image in order to safeguard the patients' realistic perceptions of the therapist. There is no need for the therapist to act in ways that encourage regression and transference distortions. These distortions will occur in abundance no matter what the therapist does. Patients are best able to work through these distortions when they have customarily experienced the therapist as a whole, differentiated person. We therefore share a number of our personal interests and ideas with the patients, although we are careful not to step across the professional boundaries into "friendship," which in fact would be pseudo-friendship.

If hostility occurs between patients, we attempt simply to dampen it by redirecting the conversation or focusing on concrete content rather than on the affect. Often this is sufficient to stop the fight. The participants often feel relieved and supported as the intense affects recede. If the anger is not diffused, we try to re-direct it toward the therapists.

When a therapist is under attack, the group, the attacking patient, and the therapist are all in precarious positions. The patients are fearful that either the leader or a patient will be hurt. They react with splitting and fragmentation. The attacking patient feels in danger, bad, and wildly out of control. The therapist feels threatened, helpless, angry, and perhaps guilty. Alone against such an attack, a therapist is hard pressed to handle the patient, the group's reaction, and his own countertransference.

A co-therapy team, on the other hand, can deal effectively with angry splitting. The therapist who is under attack can focus on the attacking patient, with the aim of conveying calm, concerned understanding. The therapist then reflects his understanding of the patient's concrete complaint, the level of the patient's anger, and the patient's feelings about the therapist. The therapist tries to maintain a sense of calm concern while at the same time engaging genuinely with the patient. This balance of
control and empathy is difficult to gauge, especially at a time when the therapist is being influenced by powerful countertransference feelings.

The co-therapist's role is to help correct the attacked therapist's empathic errors, and to handle the other group patients. The co-therapist, sitting outside of the fray, often can see why the patient and therapist are missing the meaning of what the other is saying and can point this out. He is in a better position to observe the group and to interact with the other patients, since his position is not inherently defensive. The co-therapist monitors other group patients for anxiety and models concern for the protagonists. He admits to experiencing fear and anxiety but at the same time models calm control. He "checks in" with various patients, soliciting their perceptions of the fight, their feelings, and, especially, their methods of coping with those feelings.

When all goes well, the attacking patient is left with the experience of having been truly understood. He finds that he has not been destroyed or even humiliated and that the therapist is also in one piece. The group feels that it has weathered a real storm together and may show increased cohesiveness for having done so. Often results are not optimal but still turn out well:

A young woman with severe character pathology because enraged at one of us for not taking her side against the physician at her residential facility. Despite our efforts she eventually stomped out of the room, furious. The group was initially quiet and seemed stunned. The co-therapist turned the discussion to speculation about what the young woman had been feeling regarding herself and the others as she left the room. He encouraged patients to share how they feel about themselves when they are very angry and to explore what options are open to very angry people to help them feel better about themselves. The group actively explored these topics and mobilized concern for the young woman. Several patients sought her out after the group in a friendly, supportive manner.

Severely ill patients have poor ego boundaries. The group can be used to demonstrate that each person is a separate, differentiated entity. Medication issues are a vehicle for providing this message. Patients often argue over the worth of a medicine in absolute terms: "Navane is good." "No, Navane makes you crazy. Thorazine's the only stuff that's any good." We intervene to provide differentiation: "What you've got to remember is that everybody's different. A medication that works for you may not work for somebody else, and vice versa." Two patients argued over whether or not it is helpful to call someone on the phone when one is depressed. The therapist intervened by defining interpersonal boundaries: "You know, this is just like the medications. What works for one person may not work for another person because we are all different."

SOCIAL SKILLS

The third major area of deficiency that must be provided for is the lack of social skills. The social skills of severely ill patients, particularly schizophrenics, have been explored in detail [24]. Our patients have inordinate difficulty with everyday interpersonal interactions, such as purchasing an item in a store, greeting a friend, or engaging in small talk. It is hardly surprising then that they have so much difficulty with the ambiguous and foreign task of being a patient in group psychotherapy. While patients of a neurotic group might profit by struggling to find their own way through social
difficulties, psychotic patients often need assistance to prevent their interpersonal efforts from becoming one more in a long series of failures, leading to further disorganization. Since social skills are missing, therapists must both model and teach them in a way that encourages the patients to build their own skills.

Many patients are socially isolated due to their lack of the skills necessary for meeting people and their rather oblivious attitude toward their social environment. We model involvement in the social environment by greeting the patients and inquiring about patients who are absent. We often inquire about their day-to-day activities and share some of our interests. As our group has open membership we often have new patients attending, which gives us a chance to model and explicitly teach ways to introduce oneself, and how to handle having forgotten someone's name.

We encourage the patients to assume that other people will want to know them if they are approached in a friendly, assertive manner. Withdrawn patients are allowed to keep to themselves if we think the withdrawal is a necessary defense. Some withdrawn patients, however, will socialize readily if others take the initiative. We reframe the withdrawal of these patients as "shyness" and encourage other patients to get to know the shy patients. When patients have similar, common interests or problems that they are not sharing, we may point out the similarities and encourage conversation. We might say, for example, "Joe, did you know that John is also interested in computers?" or, "Jim, you know Susan has had a lot of the same side effects that have been bothering you? She might be able to tell you more about them than we can." If the patient agrees but doesn't initiate conversation, we take it a step further: "How about asking her about it?"

We model and teach active listening, which consists of paying attention to what people are saying and letting them know that they are being understood by giving feedback or asking questions.

We encourage the patients to develop an awareness of their own actions and the effect of those actions on the other patients. We stress that patients have a lot of control over what people in the group feel about them and that they can use their actions to further their own goals:

A twenty-year-old man came to the group for the first time and after meeting the patients spoke continuously about himself for ten minutes. Other patients were silent and looked bored or annoyed. We intervened by telling the patient that we admired his ability to jump right into the group, his willingness to share so much about himself, and his desire to make new friends (which he had told us about before the meeting). But, we said, we were concerned that other patients were looking bored because they hadn't had a chance to talk, too. We suggested that he try listening to the others for a while as a way to make the others feel good so that they would be his friends. We suggested that in the future he check with other patients to see if they thought he was talking too much or not enough. The patient accepted the suggestion and was quiet. Later in the meeting he talked for shorter intervals, asking others what they thought about the length of his speeches. Other patients learned tactful ways to interrupt him when he did lapse into speeches, and they were supported for doing so appropriately. He was accepted well by the group, which had earlier begun to reject him.

We teach patients that they need not get into fights that they do not want to be in. They do not have to respond to anger with anger or defensiveness. They can, in fact,
choose which fights they want to be a part of. Partly we do this by modeling. We are continually challenged, but pick and choose which disputes we enter into. When patients are provoked, we may ask them if this is a fight they want to be part of or not, and help them find ways out of fights they do not want to be part of.

Patients are encouraged to make use of the group as a social resource. We take the patients’ expertise very seriously and refer patients’ questions to other patients, saying that the patients have more expertise in certain areas than do the leaders. We point out that although we have extensive “book knowledge” about medication, patients have much more knowledge about the subjective effects. Patients are valued as experts on the city and the social service systems. Patients’ self-esteem is greatly enhanced when they realize their own competence (for example, that they know more about getting around the city on buses than do their doctors) and find that they can help each other in important, practical ways.

In neurotic groups, patient contact outside the group meeting is usually minimized. The group is regarded as a microcosm in which the patient can develop, but the patient’s “real life” is outside the group. The patient learns in the group and generalizes to situations outside of the group. We take exactly the opposite position with psychotic groups because our patients have an impaired ability to generalize readily from one situation to another and from one relationship to another. Our patients are better able to generalize by taking an existing relationship into a new social setting and by working to solve problems outside of the group with the same people they worked with in the group. We work to establish relationships among the patients which continue outside the group. We are pleased to hear that patients call each other on the phone or take in a movie together on their own.

CONCLUSION

Therapists working with severely ill patients can maximize the therapeutic potential of many types of groups by using direct, non-interpretative actions that provide for the group that which the patients cannot provide for themselves. The deficits that must be provided for include deficits in ego function, object relations, and social skills. The therapist must make sure that the group continues to be a place of safety, that anxiety is monitored and controlled, that structure is provided, and that social skills and social connections are fostered. The structure provided by a content-focused group, such as a medication group, in itself facilitates the therapeutic process, but optimal results are obtained when therapists pay attention to both the overt agenda of the group and the dynamic group processes.

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