Bill Roller

The Promise of Group Therapy

How to Build a Vigorous Training and Organizational Base for Group Therapy in Managed Behavioral Healthcare

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Dedicated to Donald A. Shaskan, M.D.

(1912–1995)

Teacher, Mentor, Colleague, Friend

Introduction

It was my good fortune to be the first group psychotherapy coordinator for the Group Health Cooperative of Puget Sound, a health maintenance organization (HMO) in Washington state and one of the pioneers in the consumer cooperative and prepaid healthcare movement. Since that time, various mental health institutions have asked me to share the secrets of our successful group therapy program in the Northwest. These secrets can be stated rather succinctly: appropriate organizational structure plus competent personnel in a context of ongoing professional training yield a successful operation that will be flexible enough to adjust with changing conditions. As I will show, the ingenuity and creativity of any group program lies in both the details of daily operation and the purposes and values on which the program is based. Given the recent acceleration of change in the financing of mental health delivery, there are now powerful incentives to use group therapy as never before.

Group therapy in managed care systems nationwide currently constitutes less than 10 percent of all patient mental health visits. In the next ten years, the use of group therapy will rise, primarily for economic reasons, to nearly 40 percent of all patient visits. During that same period, the demand for qualified group psychotherapists will increase so dramatically that we will have to train more than thirty thousand new group clinicians.

How will this change come about? And why is it happening now? The first is a question of how we conceptualize the training needs of the new group therapists and plan for the groups their patients will need in the future. The second is a question of why consumer demand for treatment and corporate marketing of health plans are now converging in a particular historical context.

WHY GROUP THERAPY?

The field of group psychotherapy is being tested more strenuously now than at any time in its young life. Having emerged from *psychoanalysis*

and its Viennese and New York practitioners in the 1930s, group psychotherapy has survived a number of crises, cultural transmissions, and long periods of neglect by mental health professionals. Group therapists are now challenged in unprecedented ways, ironically, because the discipline they practice has met with success beyond their expectations.

Not so long ago, group therapy was considered a secondary (at best), ancillary form of treatment to be employed for reasons not well understood. Though regarded as theoretically inferior at that time, in this age of cost management group therapy has risen to the stature of a primary form of psychotherapeutic intervention. Some might say this change in status has occurred for the wrong reason, namely that in terms of industrial output, group therapy is a less labor-intensive way to deliver a product to consumers. A group therapist can treat from two to three times as many patients in one-half to one-third the time.

Capitation and Cost Control

These figures have enormous financial consequences for capitated systems, that is, cost management systems that undertake to cover a certain number of people for limited mental health benefits at a predetermined price per person. Capitation is a calculated risk that a mental health managed care system takes in writing a contract for employers who seek benefits for their employees. Because 93 percent of mental health delivery costs are personnel related, this wager will work for managed care systems only if the cost of delivery is reduced by methods that use less personnel. Thus it becomes clear why there is an urgent and extraordinary demand for group therapists to deliver their product.

Capitation is one of the driving forces behind the rise of group psychotherapy. The marketing strategy of selling capitated contracts to industry and business has become increasingly popular because it sets cost limits on the mental health benefits of employees. Under capitated contracts, a certain dollar amount is assigned to each employee with the guarantee that all necessary treatment will be given and no extra fees will be assessed regardless of the treatment needed. Under capitation, an employer can plan for the exact cost of mental health benefits for all employees and can shop around for the best mental health bargain. This situation gives rise to competition among managed care corporations to provide contracts at lower capitated rates.

Managed care corporations make a gamble when they enter into capitated contracts with employers. They bet that they can meet the mental health needs of the covered populations within the dollar amount they have bid. This financial risk motivates those managed care operations to provide lower-cost mental health alternatives. Group psychotherapy becomes a highly desirable treatment option under these conditions, and the development of group psychotherapy programs becomes paramount as a cost containment strategy. Group psychotherapy also becomes part of the marketing strategy. If a flourishing group therapy program is a component of my managed care operation, I can afford to sell a company a capitated mental health-care package at a lower price. As utilization increases, I can make my payroll by providing group therapy.

There are other ways to control costs besides using capitated contracts. Some managed care corporations control patient utilization rates by limiting access to mental health services through such formal and informal "gate keeping" procedures as proving medical necessity, allowing lengthy patient waiting lists, and remaining inaccessible by phone. In systems that do not sell capitated contracts, there are fewer incentives to provide group therapy.

Market Demand

Another driving force behind the desire to increase the implementation of group therapy is the prospect of a vast population using mental health services. In recent history, all industrialized nations in the world (with the exception of the United States) have found it a necessary element of their social organization to provide for the health needs of their citizens. In the near future, 300 million Americans, including the underserved population of poor and uninsured citizens, could be fully covered under the health plans of managed care corporations, HMOs, or government-sponsored single-payer plans. If we subtract 50 million because of unsuitability for mental health treatment (for instance, infants, as well as certain portions of the infirm and aged population), we have 250 million people eligible for potential mental health benefits. Managed care systems currently estimate that 3 to 6 percent of covered populations will use mental health services each year.

I find this estimate unrealistic over the long term, because it does not take into account the skyrocketing utilization rates that occur after

natural disasters and other catastrophes. For example, one earthquake in California could treble utilization rates there for years to come. Especially pertinent in that regard is the proven efficacy of group treatment in the wake of calamities that bring large-scale trauma to the public. A more realistic figure is obtained by examining utilization rates in HMOs over the past few decades. The HMO industry has found that across its history 10 percent of their populations sought or required mental health treatment in a given contract year. A 10 percent utilization rate means some 25 million Americans will need or want mental health services in the United States annually.

Members of the American Association of Health Plans, formerly the Group Health Association of America (GHAA), who have developed state-of-the-art group therapy delivery systems for their capitated or otherwise covered populations, have discovered that 40 percent of the people who seek or require mental health treatment are appropriate for treatment by the full range of services provided by a comprehensive group therapy program. That means that 10 million Americans are suitable for treatment in appropriate therapy groups each year.

So what will it take to provide service for such a market? Dr. Michael Freeman, president of the Institute for Behavioral Health, estimates that the ratio of mental healthcare providers to patients in a managed care environment is between 1 to 3,000 and 1 to 6,000. Taking the lower end of Dr. Freeman's estimate, we can allow one provider for every 5,000 people fully capitated. If we take the 1 to 5,000 ratio of providers to capitated population, and assume that 10 percent will seek or require mental health services, then each provider will need to treat 500 patients each year. A competently trained and skilled group therapist can conduct about eight 90-minute groups every week. Each group can treat 32 patients per year (because the average stay of each group member in an 8-member group is 8 to 12 sessions), for a grand total of 256 patients. In this manner, a skilled group therapist could deliver service to more than half his yearly patient load in only 12 clinical hours per week.

At 250 patients in group treatment per year—the very maximum for highly trained and competent group therapists—we will need 40,000 group therapists in order to provide groups for 10 million people each year. The current membership of the American Group Psychotherapy Association, the premier association for group psychotherapists in the United States, is approximately 4,000 *practi-*

tioners nationwide. There are probably another 4,000 therapists in the nation qualified by training and experience to practice group therapy. That means we will need to train 32,000 competent group therapists to meet the needs of the nation—assuming that all of the current group therapists continue practicing.

TRAINING THE GROUP THERAPIST

At the present time, there is no university or college in the United States that offers a comprehensive training program in group therapy. In the absence of educational institutions able to prepare qualified group therapists, I believe the HMO and managed care industry will have to train their own group therapists in comprehensive on-the-job training programs of one to three years' duration, depending on the level of skill required. The pressing need to develop programs to educate the next generation of group therapists is one of the chief motivations for writing this book.

In this book, I will set forth the necessary conditions for the training of competent group therapists in an organizational setting and the necessary conditions for the organization to provide a context in which the group therapist can succeed. Competence is defined in terms of functional tasks that must be accomplished. The question of mastery—always an elusive one in any high craft or art—remains open and is the subject of another work in progress, *The Pursuit of Paradox: Group Therapy, Equality, and Other Experiments With Democracy in America.*

Research has shown that a person's first exposure to group therapy leaves lasting impressions. If we want our patients to learn the purposes and values of group therapy, it is incumbent on us that we help to make the patient's first experience a positive one without minimizing the struggle that often occurs. The therapist's responsibility to be competent as group leader is paramount.

Paradoxically, the clinician who intends to practice short-term therapy and time-limited groups, as often mandated in managed care settings, must be *better* trained and prepared than her counterpart who conducts long-term groups. This is true for three reasons. First, the leader has less time to learn from mistakes in short-term treatment. She must read group situations rapidly and accurately, and respond appropriately within the time allotted. Second, the potential to harm patients is increased because there is less time for the leader to correct

mistakes. The phenomenon of scapegoating alone—the most frequently encountered crisis in group—carries the possibility for harm. Although scapegoating must be processed and integrated by every group, the scarring of individuals is not necessary and can be averted by skillful leadership. Third, because the bond the group therapist makes with the patient may be minimal, the group cannot rely on the strength of the patient-therapist relationship to make up for a lack of skills or facility with the group.

HISTORICAL BACKGROUND

One of the practical breakthroughs of social psychology in this century has been the development of group psychotherapy as the primary method for addressing the individual's problems of isolation and alienation and for meeting the human needs of socialization, acceptance, and healthy adaptation in the community.

There are many geniuses and pioneers who have contributed conceptually and pragmatically to the founding and advancement of group psychotherapy—I will name but a few here.

Joseph Pratt, an internist, met with tuberculosis patients in groups as early as 1905 in Boston, to give them information and help them cope with their illness. Trigant Burrow was a pioneer of training groups and the laboratory approach to the study of individual behavior in groups in the 1920s. In Vienna during the 1920s, Jacob Moreno applied dramatic methods to a form of group treatment he called psychodrama, and Alfred Adler met with children and adult patients in group settings.

Paul Schilder, a Viennese emigré in New York, extended the psychoanalytic concepts of transference and dream interpretation to the practice of group therapy in 1936, and developed the idea of the body image as it related to group interactions. Also in New York, Louis Wender linked Sigmund Freud's ideas on group psychology with the appearance of family transferences in the treatment groups he conducted in the 1930s. About that time, S. R. Slavson began helping children become more spontaneous in the context of group activity. In 1947, Kurt Lewin brought the Gestalt notion of studying whole patterns to self-study groups at the National Training Laboratory at Bethel, Maine, leading the way to action research in the social sciences.

The need to provide treatment to thousands of psychologically impaired Allied soldiers during World War Two took the medical and

psychiatric profession by surprise and introduced them to the benefits of group therapy for a large patient population. The necessity to treat so many combatants and the goal to return as many as possible to active duty spurred the evolution of creative methods in group intervention. Psychiatrists trained in psychoanalysis were obliged to improvise with their patients. American and British military hospitals provided training opportunities and advanced the professional careers of many who later became authorities in the field.

With the passage of the Community Mental Health Center Act of 1963, group therapy was given yet another stimulus, as thousands of citizens used the newly founded community mental health centers. Reflecting on the pressures of that time, Saul Scheidlinger reminds us that the current temptation for managed care organizations to employ unprepared clinicians as group therapists has an historical precedent. "The knowledge and the experience of group therapists in outpatient, inpatient, and preventive contexts were in demand. In fact, lacking a sufficient number of skilled group therapy practitioners, harassed administrators began to resort to rash solutions, among them assigning untrained staff persons to work with groups" (p. 4).

The community mental health movement in the 1960s and the human potential movement in the 1970s, with its burgeoning group modalities, found encouragement in the idea that the individual might gain insights into the self by meeting with a group of peers. Psychological research has since shown the effectiveness of group therapy in overcoming isolation and promoting socialization among varied patient populations.

GROUP PSYCHOTHERAPY AT PUGET SOUND

In the early 1980s, my colleagues and I at the Mental Health Service of Group Health Cooperative of Puget Sound created a state-of-the-art program for the delivery of group psychotherapy to a large population (300,000 members) covered under a prepaid comprehensive health plan. This was a staff model HMO, meaning that our mental health service had a salaried staff of sixty-plus support personnel functioning at five different sites in western Washington state. Within a four-year period, we had developed the largest group therapy delivery system in the nation, serving a diverse population of patients in one hundred psychotherapy groups each week. Ninety percent of these

groups were designed as short-term group therapy, which we defined for the individual as a course of treatment consisting of eight to twenty sessions over a three- to six-month period.

I have distilled much of what we learned in that development process in the pages of this book. Of particular note is the way in which we applied the principles of organization development to the task. Organization development is the study and practice of how the organization and the individual interact in a specific context. Understanding the context in which both individual and organization interact is essential to shaping a group therapy program.

Motivation

The motives for the Mental Health Service to expand the group therapy program were threefold.

1. We wanted to reduce the costs for out-of-plan referrals, that is, the additional cost necessary to send a plan enrollee to a clinician outside the Mental Health Service because of our lack of services or capacity to treat the patient.

2. Use of mental health services by consumers was increasing for a number of reasons, including medical staff recognition that appropriate and timely referral of a patient could result in lower medical costs overall by preventing injury, illness, or death. (See the discussion of the offset effect in Chapter Seven.) In the face of increased utilization, group therapy became a practical and clinically sound solution to providing treatment in-house.

3. Although required by regulation to provide mental health services (as was every government-qualified HMO of the time), the management of the Group Health Cooperative of Puget Sound did not want to continue to do so, and actively lobbied at the state and national levels to be relieved of that responsibility. To management, the savings of the offset effect seemed vague, and would show only in the long term, whereas the savings of removing the mental health benefit, including the Mental Health Service, were immediate. The chief political factor that kept the mental health benefit alive was a small but dedicated group of citizens—members of the HMO who were highly vocal and effective in lobbying their elected representatives to keep their

mental health benefit. With the help of consumer allies, the Mental Health Service was allowed the time to expand its group program and significantly limit its out-of-plan referrals to a handful of extraordinary cases.

What Corporate Management Needs to Know

My experience at Puget Sound illustrates the three elements essential to the managed care system: (1) a financial organization that makes contracts with employers and hires professionals to provide treatment, (2) professionals highly qualified to deliver services, and (3) consumers who receive professional treatment as part of their contracted benefit. These elements have remained constant for nearly a century of developing prepaid, capitated health plans. However, the relative power that each element held has shifted extensively in the last five years in the direction of the corporation and its financial imperatives.

Although the recent transformation of American healthcare management has taken many in the field by surprise, it was not unanticipated. As early as 1982, Paul Starr predicted in a chapter entitled "The Coming of the Corporation" in *The Social Transformation of American Medicine* the rise of corporate control in medical and related fields:

> The emergence of corporate enterprise in health services is part of two broad currents in the political economy of contemporary societies. The older of these two movements is the steady expansion of the corporation into sectors of the economy traditionally occupied by self-employed small businessmen or family enterprises. In this respect, the growth of corporate medical care is similar to the growth of corporate agriculture. The second and more recent movement is the transfer of public services to the administrative control or ownership of private corporations [p. 445].

In this climate, employers paying higher insurance rates increasingly began to distinguish their economic interests from those of the healthcare industry. In the absence of public control and in the face of rising costs, employers and insurance companies set about to establish a system to manage costs.

If Starr is correct in his pronouncement that medical planning has now become the discipline of medical marketing, then it is imperative that corporate marketing personnel understand the product they

are selling. In the case of group therapy—the hands-down winner of cost containment in the mental health industry—the marketing people need to understand the essential conditions that must prevail in order for the group therapy program they have sold to deliver the services promised.

Another impetus for the corporate health service industry to comprehend the art of group therapy is the need to be accountable to the public. The recent disciplinary action by the Rhode Island Department of Health underscored the failure of one managed mental healthcare company to address the complaints of patients and their families about delays and denials of treatment for seriously mentally ill patients.

With the rise of a more sophisticated mental health consumer, corporate entities must be better prepared to meet the real needs of their patients, lest subscribers seek to redress their grievances in court or by the sanctions of state regulatory commissions. State-of-the-art group therapy programs and competently trained group therapists have the technology to provide the treatment necessary for these patients and to avoid costly legal battles and disciplinary actions.

ABOUT THIS BOOK

I wrote this book for mental health professionals who find themselves in the current managed care marketplace working for staff model HMOs or professional groups organized to serve individuals under capitated contracts. These workers include the following:

- Clinicians with little or no training and preparation who are required by their employer to conduct groups
- Supervisors of group therapists who are asked to supervise without sufficient training or mastery of the subject
- Mental health clinic managers who are instructed to increase the percentage of group therapy visits without prior knowledge of systems theory or organization development as applied to mental health delivery
- Students of group therapy who want to learn the systematic progress of a group through the various phases of development that parallel the individual's growth in group

- Group therapists who want to integrate into their practice the notions of object relations, systems theory, Redecision Therapy, the emergent leadership roles of Ariadne P. Beck, and the stages of a group therapist's personal and professional development

Many of these readers will feel the rush to fill the demand created by a new industry and will want to know answers to the following questions: What are the possibilities and limitations of group therapy? Given the context of strictly limited benefits, what people can be served by this method? What patients will require systems that offer more comprehensive and time-consuming treatment plans? How can we make the introduction to group therapy positive for people who generally express a culturally determined bias for individual treatment and no small amount of trepidation for group treatment? How can the group therapist build from the start an expectation of help within the patient? How must the group therapist be trained in order to shoulder such responsibility? How must the organization create a context that will allow the group therapist to be successful?

ORGANIZATION OF THE BOOK

The first eight chapters of *The Promise of Group Therapy* formulate in detail the support the group therapist must receive from the organization in which the groups develop. Special assistance from each level of the managed care system is essential for the success of the group therapists and the program they create together. The organization must be willing to experiment with new ways of conducting groups and at the same time be respectful of patient rights and cognizant of the responsibilities borne by the clinicians who treat them. The final five chapters address the issue of competence and illustrate what the clinician must know in order to lead well. This second part of the book is a companion volume to six hours of videotape that clearly illustrate the theoretical considerations outlined in the text. This video has been edited from sixteen and a half hours of live group therapy sessions led by Vivian Nelson and me. We are a married co-therapy team that has collaborated professionally for over twenty-one years. Viewers of the videotape will see us model leadership in a time-limited group and demonstrate therapeutic interventions appropriate to the level of the group's maturity.

Mastery in the field always implies a large degree of first-hand learning. Through observation of the interaction of group members, the viewer can see the development of group phases and the emergence of leadership roles predicted by Ariadne P. Beck of the Chicago Group Development Research Team. Specifically, the video shows the behavioral markers that define her phases of group development and illustrate how leaders with specific roles emerge from the group's membership to assist in the transition from one phase to the next. The viewer will be able to familiarize herself with these and other theoretical considerations crucial to the practice of group psychotherapy. I have made references in Chapters Eleven and Twelve of the text to certain parts of the video, which we have created especially for our readers. We trust the dialectic between theory and action, description and visual image, method and *in vivo* modeling will prove useful in training both the eye and ear of the clinician to the many phenomena of group therapy. (Videotape ordering information appears following Chapter Thirteen.)

PROSPECTS FOR GROUP THERAPISTS

Group therapists, as mavericks in the mental health community—never quite accepted nor fully appreciated—stand in amazement at the threshold of prodigious growth in their profession. Will their skills at last be used by the millions who are appropriate for group treatment? Will they be welcomed to train a new generation of practitioners in the subtleties of the art they so love? It would be unfortunate and highly ironic if the new corporate management of mental health overlooks or underestimates—as once did the psychiatric, psychological, and medical communities—the profound power of group therapy to influence behavior and heal.

I have written this book based on the premise that a specific course of organizational preparation and professional training will lead to a high-quality product. I present these ideas both as a prescription of what we can do in the short term and as a general outline of how we must proceed in the long term, if we are going to take advantage of the opportunities that await us.

The promise of group therapy lies yet before us. My hope is that consumers, providers, and corporate managers, for a variety of political, regulatory, and economic reasons, will cooperate to inaugurate a

golden age of group therapy teaching and practice that will stimulate innovative methods and action research and build a strong foundation for our profession as we enter a new century.

Berkeley, California
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BILL ROLLER

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B.R.