FRED CUTTER, PH.D.

Patient-led discussion groups in a state hospital

The concept of patients helping other patients is an old one. However, the systematic use of patients as group leaders, in an effort to help other patients work through their disturbed feelings, is relatively new. The classical outlook assumes that all therapy stems from staff. Patients are seen to be passive recipients of "good" with peers as competitors for staff time. Actually, effective staff-led therapy presumes the good will, co-operation, and interest of the patients. Patient help in the laundry and kitchen has long been considered appropriate and even therapeutic.

Is it not equally appropriate and therapeutic to utilize patient help in facilitating peer patient self-expression, understanding, and better reality testing? The approach suggested by the writer assumes that each patient has a potentiality for good in terms of social rehabilitation. The use of patient group leaders to supplement the therapeutic activities available for patients is an evolution in the concept of the treatment setting, an evolution that moves in the direction of the increasing use of patient initiative, energy, and good will (11).

At Atascadero State Hospital, a tradition has developed in which the principle of mutual help and acceptance is central. This tradition is manifested in terms of patient government, staff-led group therapy, and co-operative activities aimed at improvement of the patient community: e.g., patient newsletter; car pools for visitors; information and public relations with relatives, judiciary, and professional personnel; patient recreation and entertainment, finan-

Dr. Cutter is a clinical psychologist at Atascadero State Hospital, Calif.

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cial assistance, mutual education, etc. (1, pp. 17–20). Patient-led discussion groups are one of the efforts made by the patients to help each other. Like most of the patient activities, patient-led groups are an effort to meet a need.

When sex psychopaths were first admitted for treatment at Metropolitan State Hospital, the shortage of trained staff produced an acute need for staff-conducted therapy. The presence of nonpsychotic patients permitted the use of patient leaders as one possible solution. Subsequently, patient-led discussion groups have existed at Atascadero State Hospital since its opening over four years ago (10). Currently, there exists a sufficient number of professional staff to permit the assignment of a therapist (physician, social worker, or psychologist) to every sexual psychopath committed to the hospital.

Good group leadership requires many and varied qualities. Some minimal common denominators are: an accepting manner, personal security sufficient to permit group process to run its course (even when the leader is verbally attacked) and subsequently to be able to make use of any group consensus that occurs, and the ability to focus group attention on pathological behavior. A fourth quality differentiates the trained from the untrained group leader; this quality refers to the body of knowledge called psychodynamics and psychopathology. Such knowledge is usually obtained by academic education, on-the-job training, and personal experiences. The absence of this knowledge limits the helpfulness of patient-led groups and restricts them to a "supplementary" role. Nevertheless, it must be stressed that technical knowledge will not replace a humane acceptance and therapeutic optimism toward individual patients (6).

By "supplementary," the writer has reference to certain natural advantages that patients have over nonpatients by the nature of their disorders. Thus, patients are potentially more sensitive to problems in others, which they themselves are experiencing. Given the atmosphere of acceptance and mutual involvement that obtains in small groups, the patients are usually able to utilize their sensitivity in a socially helpful rather than a defensive manner. Associated with such an interest is the effort to seek improvement of a peer with a similar interpersonal problem because of the identifications which develop in the course of hospitalization. Patients have more time and energy, which, together with more intense interests in a peer patient, permit a more extensive—albeit blundering—kind of working through of morbid feelings, in comparison with staff effort. The supplementary working through of these feelings tends to permit the staff therapist to move faster in his efforts to uncover deeper or additional areas of disturbance.

However valuable the foregoing may be, by far the most vital role filled by patient-led discussion groups is the mutual support which is always forthcoming in the event of a crisis. The danger of a psychotic break, precipitated by patients, staff, or life, is minimized by the omnipresent reassurance and support provided by the peers.

Patient-led discussion groups permit certain experiences to occur which otherwise would not be available to the patients. Some of these experiences are indicated here. Thus, patients have the preliminary opportunity to work through their distrust of people by confiding in their peers. Favorable experiences with their fellows permit the patient to bring up the same or deeper material for his staff therapist.

Patients in a group, like students, tend

to be more accepting and simultaneously more critical of each other. Thus, a given patient can be exposed to more severe criticism than staff could give, yet always in a context of sufficient support. The experience of being a leader of a discussion group permits the patient to see himself in a radically different light. This experience is perhaps best described in the adage "It is better to give than to receive." The advanced patient who has worked through some of his grosser problems in relating is in a position simultaneously to pass on his acquired wisdom (as a senior patient) and also to benefit from the experience of being a helper rather than a needer of help.

Finally, it should be noted that there are many therapeutic advantages to a patient placed in the role of leader. That such advantages obtain are apparent to trained leaders in terms of their own improved insights from conducting group psychotherapy. Furthermore, these advantages accrue to the patient leaders as a result of advantages that exist for the peer patients rather than (as is often supposed) at the expense of the peer patients.

Some criticisms have been made, and difficulties do occur. However, these criticisms were largely in terms of "what could happen." Typical objections were: the danger of exploitation of one patient by another, either deliberately or on the basis of unconscious needs; violation of confidences revealed, with overtones of blackmail; danger of psychological damage because of unskilled leaders, and the possibility of patients coaching each other with the "right" answers. In the experience of the writer, such pitfalls simply did not occur. The major difficulty the writer experienced was associated with the fears and resistances of colleagues. Some of the fears were based on the a priori expectations cited previously. Favorable experiences were sufficient to resolve such apprehensions. On the other hand, some of the staff were genuinely resistive because of personal anxiety associated with perceived threats to their self-esteem as "trained group leaders."

A precursor to the use of patient leaders was the use of untrained employees as group leaders. The experiences with these leaders demonstrated the practicality of using untrained therapists (7). Thus, early results showed that the use of psychiatric attendants in a state hospital produced immediate improvements in communication with the backward or regressed psychotics. The clinical director was made aware of changes in mental status of these patients as soon as these changes became apparent to the leader. Secondly, the patients were given, and responded to, the additional staff attention, interest, and therapeutic optimism implied by the activity itself. Thirdly, the psychiatric attendants themselves began to change their outlook toward these disturbed people. Perhaps even more profound, the untrained leaders began to develop more self-acceptance and job satisfaction.

Another precursor to patient-led discussion groups is the experience of Bion and Rickman as reported by Bierer (3). Here, the staff leader's role was so passive as to be nonexistent; hence, a leaderless group. This technique has been described by Bach (2) under the rubric of "leadership by default." While not directly comparable to the present approach, both Bach and Bierer suggest that there are advantages to psychotherapy where the leader's overt participation is minimized and his authority delegated to the group at large.

In California, as elsewhere (4), increased therapeutic activities and responsibilities are being given to psychiatric technicians

(12, 13) in the Department of Mental Hygiene as well as to custodial and maintenance personnel in the Department of Corrections (5, 8). So far, the results seem to be in the direction outlined above. If these advantages can occur because of untrained personnel, it would seem reasonable to anticipate similar results with patients. This would seem even more likely with patients who are not psychotic and who are given an additional or supplementary method for resolving their interpersonal problems.

Since the concept of patient-led discussion groups implies the absence of observation by staff, supervision of patient leaders poses a difficult task. The inherent potential for good must be assumed from the outset or else the whole operation is impossible. However, granting that patients intend to help each other, in what manner can staff provide effective assistance and direction?

Three additional assumptions can be made that permit the staff consultant to draw conclusions concerning the nature of the patient leader's activities and subsequently to influence them. The first permits the staff consultant to infer the nature of a given patient's role as group leader. When the patient leaders meet with the staff consultant in an unstructured group therapy-like meeting, the patients tend to perceive the staff leader in terms of their own preconceptions of good and bad leadership. The consultant can observe directly the nature of a given patient's perceptions, motivations, and expectations toward the staff leader. In short, the patient leader will relate to the staff leader in terms of the structure imposed on the peer patient group: e.g., if the patient leader perceives the staff leader as snobbish about education, one can expect to find the same patient reacting to his own peers snobbishly with respect to education. Another example would be the patient leader's misperception of the staff leader as knowing all the answers. This same patient would tend to impose a know-it-all role in his patient-led group discussion.

The second assumption concerns the staff member's effort to facilitate better group leadership by the patients. Patient leaders, and staff leaders too, tend to structure their groups according to their own needs, values, and preconceptions. Such an alteration of a need, value, or preconception subsequently alters the nature of the group structure. Since his primary responsibility is to improve group leadership, the staff consultant does not attempt a broad effort at psychotherapy. Instead, he addresses himself to the specific needs, values, and preconceptions that interfere with good group leadership. Thus, the staff leader conducts group psychotherapy with highly selected goals for the patient leaders. The goals in this situation are the modification of those factors that determine a patient leader's notion of "good" leadership. Where his preconception of the good leader is recognized as detrimental to effective group processes, the staff consultant should attempt to work through the source of the patient's attitudes. The sources are visible during the course of the meeting with the consultant, albeit in terms of the inverted leader-peer relationships.

The third assumption concerns a more indirect method of influencing the patient leaders. The staff consultant, by his behavior, provides a model of the good leader for the patient leaders. His example, manner, and attitudes become ego ideas which the patients tend to introject in their efforts to lead patient discussion groups adequately.

In his efforts as staff consultant, the writer attempted to conduct his group of patient leaders in the following manner:

First, an attempt was made to provide an atmosphere of acceptance and safety for the patient leaders in the group led by the staff consultant. This effort was achieved by permitting attendance and participation to occur on a voluntary basis. In addition, patients were allowed to move at their own rates with respect to such issues as being evasive or noncommittal at any given moment, attacking or criticizing the staff leader, or persisting in some autistically derived perception even when the group consensus specifically contradicted it. A potent device for conveying an accepting attitude was the specific intervention on behalf of a given patient at times of pressure or distress. Such intervention was intended and perceived as giving relief to the patient in his hour of most acute need, even though this, in effect, prevented the group from achieving its objective.

The staff consultant indicates by his behavior that any subject matter is legitimate, regardless of how trivial or irrelevant it may appear to be. However, by periodically asking the group, "Why are we discussing this topic?" the staff leader brings attention to the underlying motivation. It soon becomes apparent, in terms of patient needs, whether or not a given content is relevant for discussion.

In addition to the foregoing, the role of the group leader, as demonstrated by the staff consultant, stressed efforts at focusing attention on the irrational behavior of any one member who was voluntarily presenting an issue to the group. The group's attention was directed, by means of the leader's verbal invitations, to describe, react, or otherwise comment on the behavior of the patient discussing his problem. Specific interpretations are left to the members of the group. By this example, the consultant conveys a preference for group judgments rather than leader interpretations. Thus, the likelihood of promiscuous or arbitrary intellectual interpretations by the patient leaders is diminished, if not entirely eliminated.

The use of patient leaders for discussion groups represents an evolution in the concept of the treatment milieu for mentally disturbed patients. This approach mobilizes patient energy, interest, and good will for the purpose of mutual aid. In the process, a more effective working through of morbid feelings occurs. In view of the typical limitations on available staff effort, such extensive working through can be presumed not to occur, or to occur insufficiently, unless alternative measures such as the foregoing are provided. However, the most profound aspect of the patient leader program is the alteration in the self-image of the patients selected as leaders. To be perceived as a giver of help rather than as a needer of help is a self-enhancing process. It tends to dissolve the arbitrary stigma of abnormality and facilitates greater self-acceptance. Such a program supplements the hospital-wide effort at rehabilitation by preparing the individual for a contributing role in society, which, ultimately, is the major goal of all mental hospitals.

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