Self-Disclosure, Feedback, and Outcome in Long-Term Inpatient Psychotherapy Groups

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Process and outcome measures were compared in two long-term psychotherapy groups. Measures of Self-Disclosure and Feedback were based on analysis of videotaped sessions by use of Bales's SYMLOG three-axial system. These measures were then combined to form a measure of Interpersonal Work. High Interpersonal Work scores, both in early sessions and throughout treatment, predicted better outcome for individual members at 18-month follow-up. Interpersonal Work scores in later group sessions were not related to outcome. Findings suggest that early sessions are a critical time for members to develop a working style in the group. Members who fail to do so have a less successful outcome even if their working styles improve in later sessions.

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This article provides further information regarding two long-term psychoanalytically oriented groups run in an intensive inpatient treatment hospital. An initial article based on these same groups[1] demonstrated that a patient self-report measure of "Relatedness" predicted outcome at 18-month follow-up. However, a measure of "Group Work" was not correlated with outcome. This discrepancy occurred because the least successful members saw the group itself as working but rated their reactions to it at the lower end of the Relatedness scale. This suggests that they perceived the group accurately, at least in the same manner as the rest of the members, but were not themselves able to align with that working atmosphere.

A second article extended these findings by looking at the actual behaviors occurring in the group.[2] Five therapeutic factors were measured by using both patient self-report and process ratings of videotapes: Emotional Relatedness to the Group, Self-Disclosure, Feedback, Interpersonal Learning-Output, and Family Reenactment. All five therapeutic fac-

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tors appeared to contribute to a positive outcome. Self-Disclosure and Feedback were highly correlated.

> The picture that emerges is one of a complex interdependency among the three therapeutic factors of Cohesiveness, Self-Disclosure, and Feedback that promotes a working through process that is also apparent in improved interpersonal patterns (Interpersonal learning-output) within the group and productive and enduring intrapsychic changes in object and self-representations (Family re-enactment).[2] (p. 206)

The present article investigates in more detail the relationship between Self-Disclosure, Feedback, and outcome. In particular, the concept of "Interpersonal Work" is introduced as the combination of Self-Disclosure and Feedback. The following specific hypotheses are investigated:

1. Patients demonstrating higher overall levels of Interpersonal Work will have greater clinical improvement than patients reporting lower levels of Interpersonal Work.
2. Levels of Interpersonal Work in the early group will predict 18-month follow-up outcome status.

"Interpersonal Work" is described in the group literature as comprising two components: "Interpersonal Output" and "Interpersonal Input."[3] The key component of Interpersonal Output is Self-Disclosure. It is assumed that the revelation of important personal information will promote a process of self-understanding and mastery. Interpersonal input is centered on the idea of feedback to the individual from other group members regarding the nature of the information they are revealing or their behavior in the group. These two mechanisms are believed to result in an environment in which interpersonal learning can occur and result in a "corrective emotional experience." It is for this reason that group therapists continuously struggle to maintain a focus on the here and now of the group interaction. This focusing is believed to have greater therapeutic power than discussion of past or current events that have occurred outside of the group.

METHODS

Clinical Sample

The study took place in the Psychotherapy Clinic, Stuttgart, Germany. This clinic is an inpatient treatment hospital with an affiliated psychotherapy research institute. The clinic accepts severely disturbed, treatment-resistant, neurotic, and personality-disordered patients as inpatients for 5 to 9 months, with an average length of stay of approximately 6 months. A comprehensive milieu program is offered, with four small-group sessions per week. In addition to this psychoanalytically oriented treatment, the program has a weekly psychodrama group session as well as athletic activities.

This investigation studied two inpatient groups, each conducted by the same pair of analytically qualified cotherapists. Each therapist had more than 15 years of experience in group psychotherapy using a therapeutic approach based on the concepts described by Foulkes and Anthony.[4]

Group 1: This group began with 10 patients and had 2 premature terminations in the first 5 weeks of the program. One of these was the only patient with a history of schizophrenia (in remission) and the other a man with a severe narcissistic personality disorder. According to DSM-III-R criteria, the remaining 8 patients had the following diagnoses: narcissistic personality disorder (3 men), generalized anxiety syndrome (2 women), schizotypal personality disorder (1 woman), dysthymia (1 woman), major depression (1 woman). The patients ranged in age from 24 to 39 years. The group completed 83 ses-

sions of 100 minutes each over a time period of approximately 6 months.

Group 2: This group also began with 10 patients and lost 1 anorexic patient because of continued weight loss at the fourth month. One man with anorexia nervosa refused to participate in termination and follow-up measurement and is therefore not included in this study. The remaining 8 patients had the following diagnoses: borderline personality disorder (2 women), anxiety disorder with agoraphobia and histrionic personality disorder (1 woman), dysthymia and histrionic personality disorder (1 woman), obsessive-compulsive personality disorder (1 man), alcohol dependence in full remission (1 man), generalized anxiety disorder (1 man), and psychological factors affecting physical condition (1 man). The patients aged in range from 23 to 35 years. The group completed 93 sessions over a time period of approximately 6½ months.

Outcome Measures

Symptom Checklist-90-Revised (SCL-90-R): This 90-item checklist is widely used as a general measure of psychological distress.[5] It is completed by the patient.

Target Goals-Patient: This form asks the patient to identify three target goals and rate their severity at different points in time (Coché,[6] pp. 79–99).

Global Assessment Scale: This is the forerunner of the current Axis V of DSM-III-R to assess overall psychological, social, and occupational functioning.[7] It is completed by the clinician.

Goal Attainment Scales: Therapeutic goals were formulated by the therapists approximately 1 month after the beginning of therapy. The ratings of change on these goals were made by an independent clinician on the basis of a 1-hour, psychodynamically oriented interview.[8]

These measures were administered prior to beginning therapy, at termination, and at 12-month and 18-month follow-ups. Outcome results were calculated for each of the four outcome measures by using "residual gain scores" calculated according to the method of Luborsky et al.[9] This procedure is a conservative measure of change because the outcome score is adjusted for the original pretherapy level of distress, the relative change from that level, and the average group change score. A global outcome score calculated for each patient was based on the equally weighted results on the four outcome measures. Process measures are compared with outcome as measured at the 18-month follow-up point. This avoids the temporary surge of either positive or negative reactions that is common at termination. A more detailed discussion of the outcome results with this cohort of patients is provided in Tschuschke and Dies.[2]

Process Measures

Videotapes of every second session were scored for all interactional acts by using the SYMLOG system (42 sessions from Group 1 and 47 sessions from Group 2).

SYMLOG, the Systematic and Multiple Level Observation of Groups method,[10] provides an objective standard for evaluating group process in terms of three dimensions: task-oriented versus emotional behavior; dominance versus submission; and positive versus negative behavior. Owing to the complexity of the measure, three psychologists were trained extensively in its use over 1 year, achieving an average interrater reliability of kappa coefficients between 0.70 and 0.75.[11] The behavioral measures reported in this article were operationalized by using the SYMLOG ACT-by-ACT scoring system. SYMLOG has rarely been used for objective ratings of therapy group material, despite its obvious relevance, because of the labor-intensive procedures required.[2,12]

The posited therapeutic factor of "Self-Disclosure" was based on the number of times a given member used two SYMLOG categories: 1) expressions that referred to the self in

the here and now of the group situation, or what the person thinks or feels about self in relation to others in the group (SYMLOG SEL [self] image level); and 2) similar material dealing with subjects or situations outside of the group: "there-and-then" material such as the past, dreams, or outside life situations (SYMLOG FAN [fantasy] image level).

A second therapeutic factor, "Feedback," was determined by calculating the number of verbal and nonverbal interactions in which a given patient was the focus of attention and interaction from others within the group (SYMLOG ACT- and NON- categories).

"Interpersonal Work" was calculated by adding the frequencies of both of the above interpersonal modes per individual and per session.

RESULTS

There was general concordance among the four outcome measures despite the different viewpoints on clinical progress: those of the patient, the therapist, and an independent interviewer. Improvement noted at termination tended to be maintained through the full 18-month follow-up period. The combined results of all outcome measures achieved an impressive overall effect size of 1.63 for the entire sample. The following group reports compare the 4 most successful members with the 4 least successful members in each group on the basis of 18-month follow-up results.

Figures 1–6 show the mean scores for Self-Disclosure, Feedback, and Interpersonal Work for the most and least successful patients in each group over the entire course of therapy. It can be seen that the most successful patients have scores consistently above the least successful patients on all three measures.

Table 1 shows the overall correlations between Interpersonal Work and outcome for each quarter of the group sessions, approximately 20 sessions per quarter, and for the total of all sessions. The analyses demonstrate that early Interpersonal Work is more strongly associated with improvement than later Interpersonal Work.

Table 2 looks at this information from a different perspective. It compares the levels of Interpersonal Work for the most and least successful patients over the same time segments. The most successful patients had significantly higher levels of Interpersonal Work in the earlier sessions and overall compared with the least successful. However, the levels were not significantly different in the later sessions. The same trend is evident. Patients

TABLE 1. Relationship between interpersonal work and outcome (Pearson correlations, two-tailed)

Sessions	Group 1 (df = 6)	Group 2 (df = 6)	Combined (df = 14)
First quarter	0.65*	0.03	0.43
Second quarter	0.71**	0.65*	0.64***
Third quarter	0.41	0.43	0.41
Fourth quarter	0.38	0.27	0.19
All sessions	0.78**	0.65*	0.71***

*$P < 0.10$; **$P < 0.05$; ***$P < 0.01$.

TABLE 2. Interpersonal work: most successful versus least successful members (dependent *t*-tests)

	Group 1			Group 2			Combined		
essions	*t*	df	*P*	*t*	df	*P*	*t*	df	*P*
First quarter	2.48	9	0.04**	0.633	9	0.54	2.36	9	0.04**
Second quarter	1.89	9	0.09*	2.67	9	0.03**	3.01	9	0.02**
Third quarter	1.75	9	0.11	0.47	9	0.65	1.38	9	0.20
Fourth quarter	2.17	11	0.05**	0.38	16	0.71	1.27	16	0.22
All sessions	4.10	41	0.00***	2.13	46	0.04**	3.99	46	0.00***

*$P < 0.10$; **$P < 0.05$; ***$P < 0.01$.

who were more interpersonally active in the earlier sessions had the better outcome.

DISCUSSION

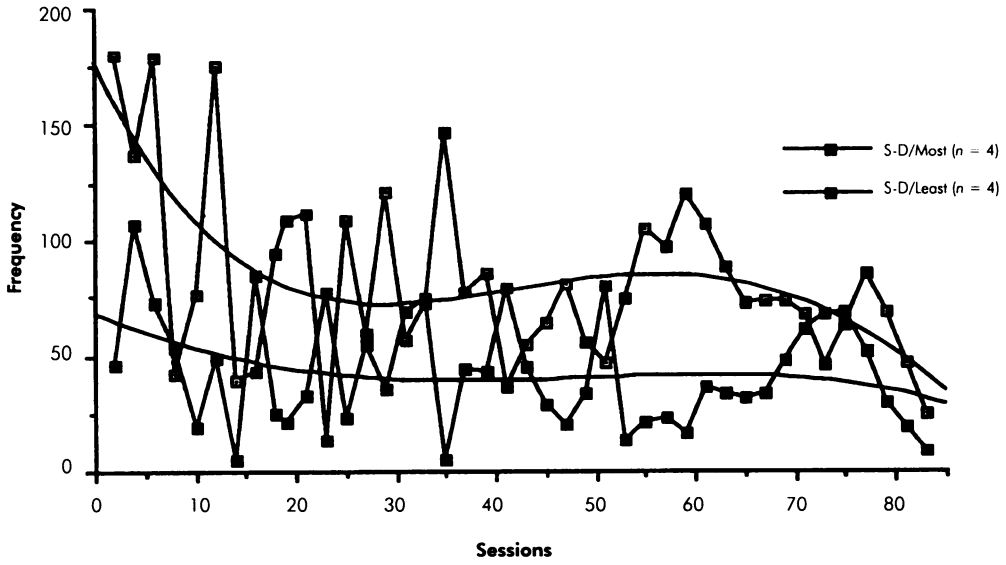
This study uses a standard comprehensive set of measures of clinical change. There is a strong common directionality to the results from the different outcome measures, even though they originate from different sources: the patient, the therapist, and an independent clinician. Gains reported at the termination of therapy were maintained at follow-up period, but patients with relatively lower scores at termination did not as a group improve these over the follow-up time period.

The process measures are based on a coherent model of interpersonal behavioral dimensions. The SYMLOG system's three dimensions permit a relatively complex picture of interaction to be developed with substantial rating reliability. The literature contains few reports regarding the application of process transcript ratings to psychotherapy groups. Such behavioral ratings form an important complementary approach to patient reports.

Hypothesis #1 is supported. Overall Interpersonal Work scores are strongly correlated with better outcome. The mean level of Interpersonal Work is significantly higher in the most successful patients compared with the least successful.

There is also support for Hypothesis #2. The most successful patients had statistically higher Interpersonal Work scores in the first and/or second quarters of each group. Thus, within the same group, members with higher levels of early-enacted interpersonal behavior made greater gains during the therapeutic experience. Piper et al.[13] report that "quality of object relations" is significantly correlated with outcome in brief outpatient group psychotherapy. This measure is based on a developmental model of object relations. Our results are compatible with Piper's finding that

FIGURE 1. Group 1. Self-disclosure: mean scores for most successful versus least successful group members.



patients with a greater capacity to relate to others demonstrate this early in the group's life. It should be noted that in both groups, the least successful members showed a surge of Interpersonal Work, both Self-Disclosure and Feedback, later in the group, but this did not translate into improved outcome. These findings support the arguments that early involvement is important and that later activity is devoted to a consolidation of changes that

FIGURE 2. Group 1. Received feedback: mean scores for most successful versus least successful group members.

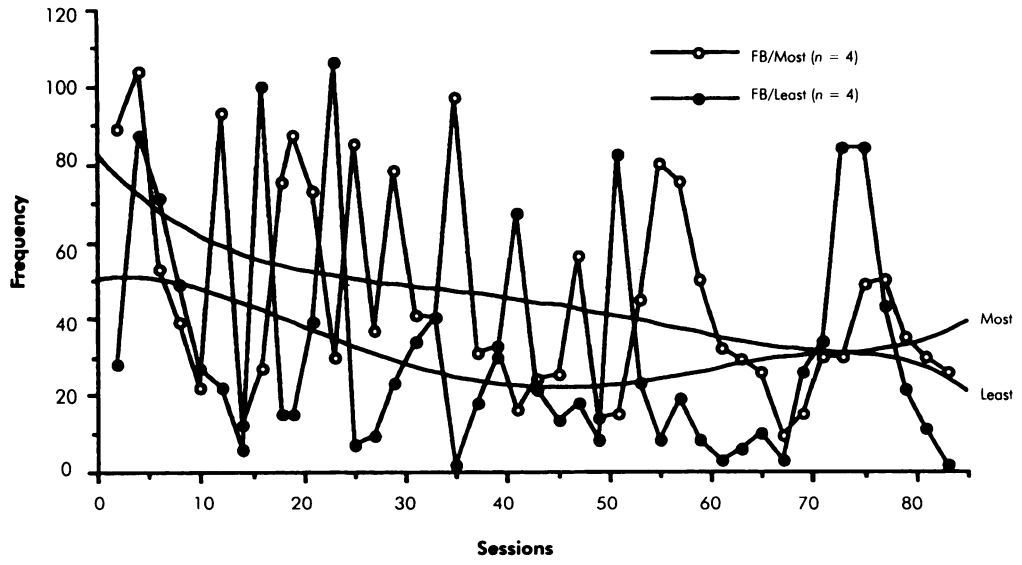
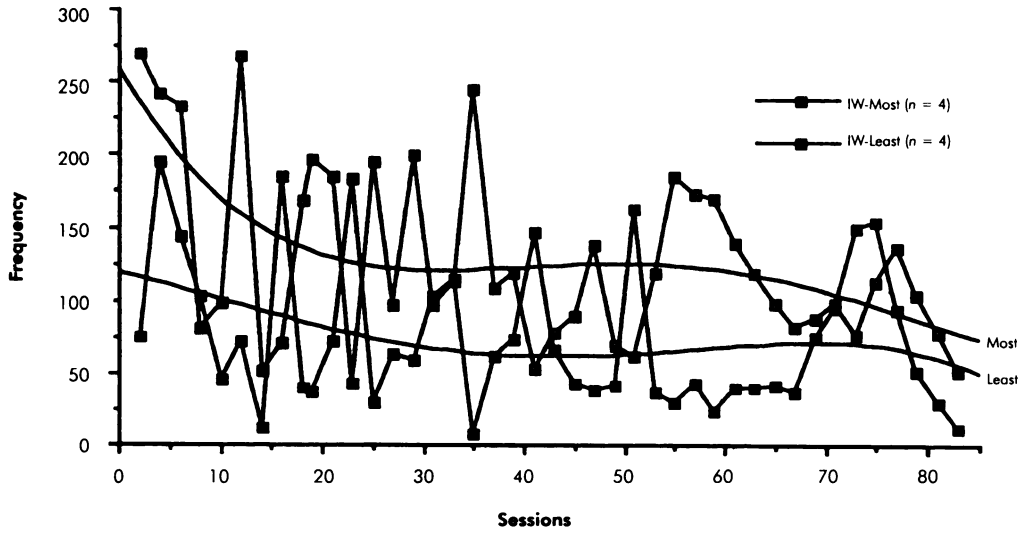


FIGURE 3. Group 1. Interpersonal work: mean scores for most successful versus least successful group members.



were initiated at an early point in the course of treatment. These results are based on segmenting members into better or worse outcome compared with the group mean. Almost all patients improved during treatment; our results highlight the differences between those who did better than others and those who did worse.

FIGURE 4. Group 2. Self-disclosure: means scores for most successful versus least successful group members.

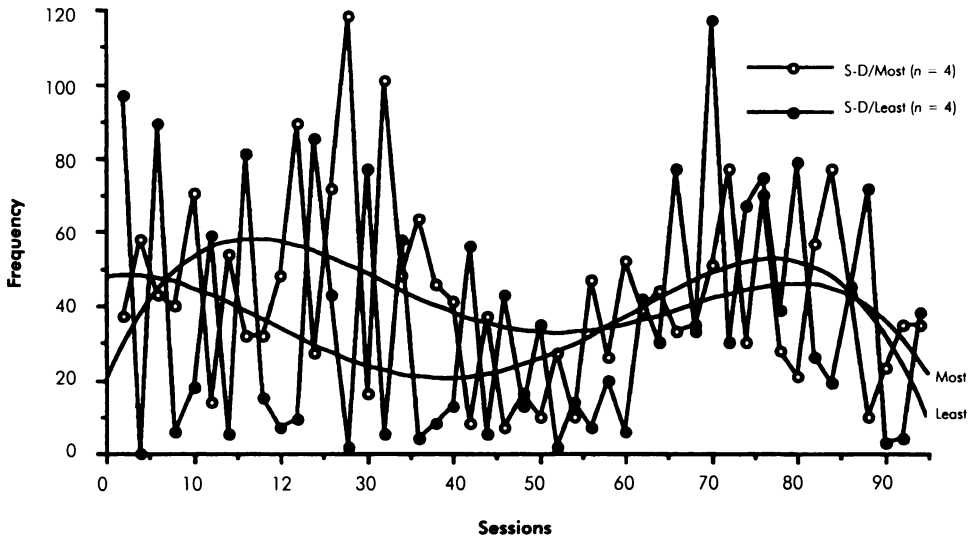
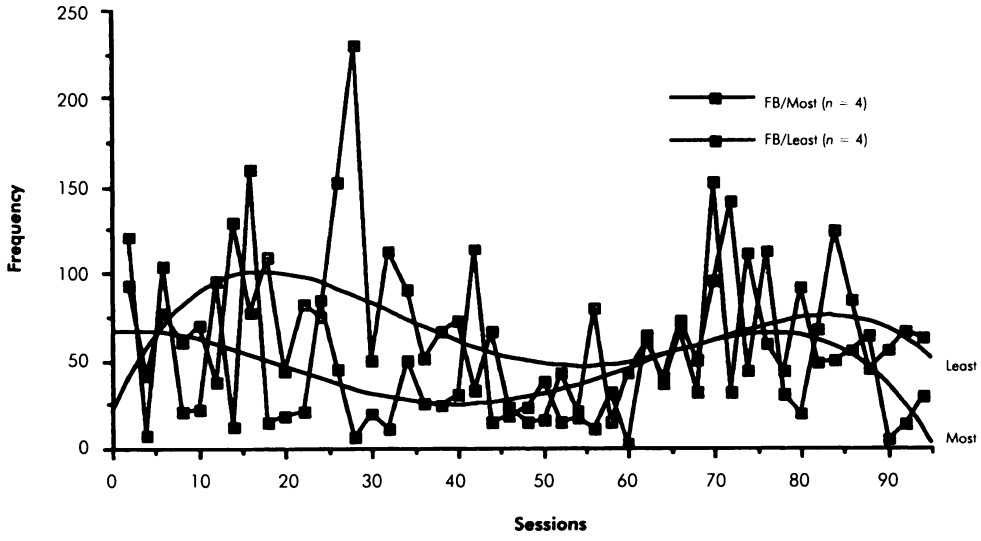


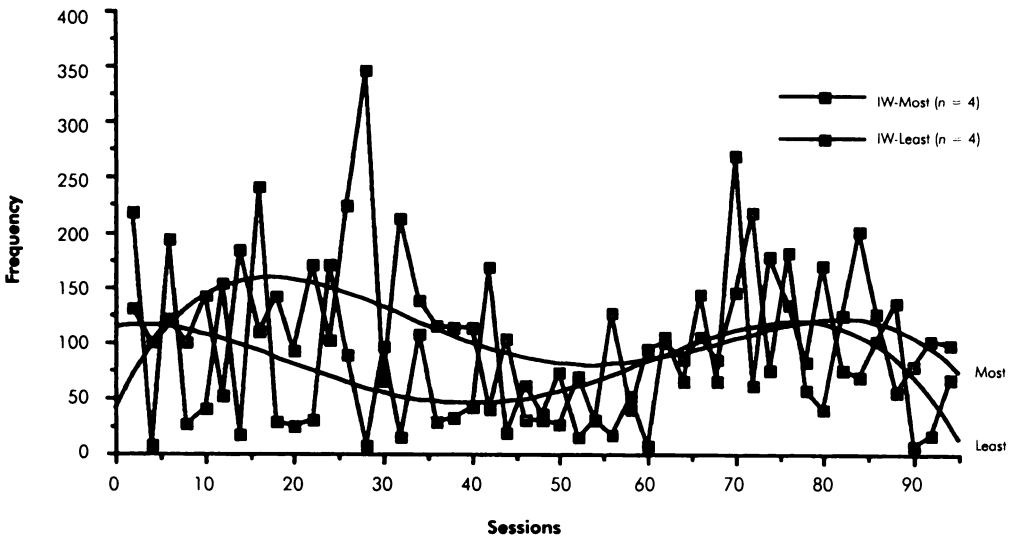
FIGURE 5. Group 2. Received feedback: mean scores for most successful versus least successful group members.



The data shown in Figures 1–6 lead to some interesting possibilities. The Self-Disclosure graphs clearly indicate that when the most successful patients are being most self-disclosing, the least successful are showing very low levels of self-disclosure. Is this the enactment of an early dominance hierarchy with some members commanding the floor? Do these members have greater interpersonal capacity so that they move smoothly and quickly into interactional group work? Is this a reflection of higher levels of psychological mindedness? Is there a subgrouping phenomenon emerging, where the in-group dominates the action? Our data do not provide answers to these questions, but they are clinically relevant issues. Our results suggest that the group therapist should be prepared to be active in ensuring that all members have an opportunity to present themselves to the group through self-disclosure. Because these patterns are most important in the earlier sessions, this action should not be delayed in the hope and expectation that the more silent members will catch up eventually. Later levels of self-disclosure did not correlate with outcome.

The nature of the feedback experience appears to be different between the most and least successful members. The most successful had many sessions in which they received feedback during the first half of the group. The least successful had less than half as many sessions where their feedback levels were elevated. Does this represent a more aversive experience for the least successful? It is almost as if they puttered along through the early group with relatively low levels of self-disclosure and periodically received a big dose of feedback. We considered the possibility that the least successful members received more negative feedback than the most successful members. However, this did not appear to be the case in any of the four quarters of the group's life. On reviewing the subcategories of the Feedback dimension, it was possible to establish that the least and most were not different in terms of task-oriented/emotional, dominating/submissive, or positive/negative feedback subcategories. This is a relevant finding in view of the possibility that feedback may be detrimental to the mental health of group members if it is consistently negative in na-

FIGURE 6. Group 2. Interpersonal work: mean scores for most successful versus least successful group members.



ture.[14] The surge of activity toward the end of the both groups suggests that the least successful members are doing their best to get their say in before termination. Unfortunately, this appears to be too little too late for optimal outcome effects.

The groups studied in this report were conducted in the complex milieu of a residential therapeutic community where many other therapeutic processes may be at work.[15-18] It is reasonable to assume that extragroup events from the milieu would be reflected in the small groups and vice versa. It may be argued, for example, that the social roles taken in the small groups may be to a considerable extent influenced by the social interactions among patients on the unit. Patients who have more popular social positions would experience greater support from the milieu and might therefore be more likely to engage in higher levels of Interpersonal Work. No specific data are available regarding this possibility. However, the inpatient literature suggests that parallel processes are likely to occur at these two levels in the ward system, that the small group is a "biopsy" of the larger system, so that our general conclusion about the importance of Interpersonal Work is warranted.

These results based on measurements of actual behavior complement those found by patient self-report. The same patients who rated themselves low on relatedness to the group[1] also showed in the present analysis lower levels of Interpersonal Work on objective measures of actual group behavior. This congruence between self-report and objective behavioral ratings provides further evidence of the importance of the nature of the bond between the individual patient and the group system.

This study has used a single-case design to look in depth at process and outcome issues in longer term group psychotherapy. By repeating the protocol with a second group, we achieved a replication of findings, thus providing an aggregation of results. Because of the small number of groups and the potential impact of the ward milieu, the generalization of these findings to less intensive treatment situations such as weekly outpatient groups is not warranted. However, these findings are in harmony with the conclusions from the literature on individual psychotherapy regarding the critical role of the therapeutic alliance in providing conditions in which positive change may occur.[19]

The findings of this study reinforce our previous conclusions. In these two groups, members who began with an early involvement in the group interactional process did better in the long run. This result draws attention to both assessment and composition criteria. Patients who have lower relationship capacity will have greater difficulty in making use of the group experience. This suggests that it might be worthwhile to compose groups with patients who are at a variety of levels to provide the opportunity for those with higher capacity to function as role models. During the early sessions, it is important for the therapist to monitor carefully the amount of self-disclosure and feedback being experienced by each member. Special care should be directed toward those who are not interactionally engaged in terms of these clearly identifiable process dimensions. Our results suggest that late bloomers do not blossom.

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