Time-Limited Group Psychotherapy

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ABSTRACT

The presence of a time limit shapes the entire therapeutic process and culminates in the management of termination. This paper outlines a protocol for dealing with termination in time-limited psychotherapy groups: (1) Select suitable members with similar capacity to use a time-limited format; (2) use a closed group format; (3) clarify the time boundaries at the beginning; (4) reinforce the time frame during the last half of the group; (5) provide focused interventions; (6) forestall premature termination; (7) reinforce termination themes of deprivation, resentment and anger, rejection, grief and loss, responsibility for self; (8) structure the final session; and (9) plan a 4-month follow-up visit to encourage ongoing application. These guidelines provide the therapist with a general structure to ensure that major termination themes are systematically addressed. They deal with powerful concepts of maturation and self-responsibility and incorporate the principal strategies that distinguish time-limited from time-unlimited group psychotherapy.

A systematic approach to the termination process in time-limited group psychotherapy is a complex topic because the entire structure of time-limited work is designed with time, and therefore termination, as a guiding perspective. The emphasis in this paper will be purposely restricted to those theoretical and technical aspects that are most relevant to termination. This material is less applicable for very brief crisis management groups with rapid member turnover. These groups are best conceptualized in the same manner as inpatient groups.

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TERMINATION IN THE INDIVIDUAL TIME-LIMITED PSYCHOTHERAPY LITERATURE

A recent comprehensive review of short-term dynamic psychotherapy concludes that termination has received relatively little theoretical or research attention (Crits-Christoph & Barber, 1991). Freud used brief treatments early in his career but eventually renounced this approach altogether (1937/1963). Other early practitioners such as Rank (1929/1973) recognized the importance of separation issues in therapy and recommended setting a termination date in advance. Alexander and French (1946) moved further from a classical analytic position by emphasizing the importance of the "corrective emotional experience" and warned of the dangers of inducing excessive dependency through frequent sessions and prolonged duration of therapy. The subsequent brief dynamic psychotherapy literature dealt primarily with techniques for defining and maintaining a focus for interpretive interventions, however, whereas termination was given relatively cursory consideration (Davanloo, 1980; Malan, 1979; Sifneos, 1987).

Mann and Goldman (1987) are an exception to this trend. By strictly limiting therapy to 12 sessions, Mann promotes a focus on termination as a means to activate core themes of self-responsibility and toleration of loss:

> With its specific time limit and the concept of the central issue, time-limited psychotherapy brings to the forefront of the treatment process the major psychological plague all human beings suffer, namely the wish to be close, to be as one with another, to be intimate, the fulfillment of which demands learning how to tolerate separation and loss without undue damage to our feelings about the self. (Mann, 1991, p. 43)

From the perspective of cognitive therapy, Beck, Rush, Shaw, and Emery (1979) underscore the effort throughout therapy to encourage patient independence. The patient's apprehensions about managing after treatment terminates are addressed as further negative thoughts to be analyzed and put in perspective. The emotions engendered by termination may be clarified and reflected, however, a process not encouraged during the earlier working stages of therapy. Garfield (1989) devotes a chapter to termination that recommends supportive techniques that do not directly address the painful issues that might be raised in the context of termination. Klerman, Weissman, Rousaville, and Chevron (1984)

emphasize the importance of dealing with termination themes in treatment of depressed patients. Although they devote limited space to the topic, termination would seem to be of particular importance for depressed populations.

A number of authors (Bauer & Kobos, 1987; Gustafson, 1986; Ryle, 1982; Shapiro, 1989) discuss the termination process as an opportunity to address fundamental issues related to the process of individuation from paternal figures and how this has shaped relationship patterns. Budman and Gurman (1988) devote considerable attention to the termination process. They espouse a "family practice" of psychotherapy, anticipating that most patients will have recurrent episodes of treatment. Indeed statistics are quoted indicating that well over half of all patients receiving psychotherapy will return for more. This applies both to those receiving quite brief therapy as well as those completing lengthy and intensive psychoanalytic treatment. They also quote an extensive literature documenting that only a very small percentage of patients receive more than 6 months of psychotherapy in one course of treatment. The practice of psychotherapy in North America, even in settings practicing long-term treatment, could be termed "unplanned brief therapy by default" (p. 6). They cite the unrealistic goals of therapists who expect total resolution of all psychological issues and the demeaning terms applied to those who seek more treatment such as "relapsers," or "treatment failures." Budman and Gurman conclude that a major focus on termination is not warranted, though a recommendation to wait several months before seeking more treatment is worthwhile to allow a consolidation of gains. This attitude is somewhat contradicted in their chapter on time-limited group psychotherapy in which the emotional power of termination is identified.

TERMINATION IN THE GROUP PSYCHOTHERAPY LITERATURE

Questions surrounding termination in the general group literature have focused primarily on how to make a decision to terminate an individual patient in an ongoing therapy group (Lothstein, 1993; Rutan & Stone, 1993; Yalom, 1995). This reflects the fact that formal time-limited group psychotherapy using a closed group model has a relatively short history. Foulkes (1975) suggests that therapists tend to err on the side of too much rather than too little therapy. He describes critical points at which

termination for an individual in a group may be appropriate: often coming up first at about 6 months then cycling back at increasingly long intervals. The literature identifies themes related to loss/grief, abandonment, anger, envy, the contingencies of existence, and the likelihood of attempts to avoid the reality of termination. Criteria for determining the timing of termination focus on achieving original goals (as defined by the patient), or the accomplishment of theoretical tasks such as "attainment of identity" (as defined by the therapist). In both cases, the language is sufficiently vague that there is likely to be considerable uncertainty regarding when such achievements have been met. Most of the existing group literature is of marginal value in considering termination in a closed time-limited group. Although similar themes are found in regard to termination in all group circumstances, the technical management of termination is quite different in time-limited groups from that in ongoing therapy groups.

Turning to the time-limited group literature, Klein (1985) provides a comprehensive overview of the relatively brief history of short-term group therapy to that point. This article, together with several others in the special issue of the *International Journal of Group Psychotherapy* devoted to this topic, is a marker of the formal acceptance of the modality. These articles discuss termination only in passing under the idea of group developmental stages. None focuses on termination as a major component of the treatment approach. Budman and Gurman (1988) describe the increasing sense of cohesion and intense emotion that characterizes the later part of a time-limited group. The awareness of time and existential pressures may elicit important work from members who have become stuck. This evidence of hard work may tempt the therapist to extend sessions, a direction to be resisted. Budman and Gurman (1988) authors recommend the use of a follow-up group session. MacKenzie (1990, 1993) conceptualizes termination as focused on the external group boundary: loss/grief and consolidation of group experiences on the inside, applying new learning on the outside. The existential position of accepting individual responsibility with associated enhancement of self-efficacy is emphasized. Piper, McCallum, and Azim (1992) cite the unique opportunity that termination presents for patients who are in group treatment because of personal loss. Termination reactivates the issues surrounding the loss and provides an opportunity for the patient to experience in the group the ambivalence that accompanies this. These issues are often worked out through reactions to the leader or to absent members. Klein (1993) also emphasizes the importance of dealing directly and vigorously with termination issues.

Hollon and Shaw (1979) treat patients with major depression in groups using cognitive therapy and cite several studies of positive results. The groups are quite structured and termination issues are handled in a didactic manner. It is felt useful to establish a firm termination date well in advance. Yost, Beutler, Corbishley, and Allender (1986) also describe the termination in cognitive therapy groups for the depressed elderly, according to supportive principles. The final sessions are focused on application and rehearsal and the group intensity is purposefully tapered. Negative thoughts about ending are explored for their validity and counterbalanced by evidence of gains achieved. Sessions may be held less frequently to allow opportunity for independent application.

Rose (1989) provides a review of cognitive groups for a variety of conditions including depression, anxiety, stress, anger management, and parenting skills. The interactive forum of the group is used to amplify learning. Skills can be practiced with modeling and feedback from other members. Peer reinforcement is emphasized. Preparation for termination is handled by gradual fading or thinning of reinforcement procedures, usually by decreasing the frequency of sessions. Patients are encouraged to find replacement support systems in the community and to become more independent of the therapist.

Overall, there is a surprising lack of attention to the termination process in the group literature. The primary focus in the research literature is on preventing premature terminations, particularly in the earlier stages of the group (Bernard, 1989; Connelly, Piper, de Carufel, & Debbane, 1986; Dies & Teleska, 1985; Roback & Smith, 1987). This is an important topic that concerns all types of group psychotherapy but is not the focus of this paper. The clinical literature tends to focus on indications for termination more than on what actually happens in the termination process (Fieldsteel, 1990; Lothstein, 1993; Rutan & Stone, 1993; Yalom, 1995). Recent work with time-limited approaches has begun to address this deficit as noted in the above-mentioned review. Cognitive and supportive treatments tend to approach termination carefully through a weaning process, whereas interpersonal/psychodynamic treatments see termination as an opportunity to address issues of loss and autonomy. The literature would suggest a major gulf between these extremes that is probably not representative of most practice settings, in which supportive and interpretive interventions are interwoven.

THE QUESTION OF TIME

In preparation for conducting time-limited groups, it is helpful for the clinician to consider thoughtfully the importance of time in human existence. This philosophical orientation makes the work of managing termination more exciting and relevant. We all chronicle our personal history and the history of those dear to us on the basis of biological time. Time is the basis for determining if we are "on track" in mastering developmental tasks. Often patients seeking therapy are dealing with major and long-standing blocks to normal developmental challenges. "At what age were you aware that things were not progressing as predicted?" Who can forget the excitement and tumult of hormonal changes in early adolescence? Think of the significance of the "biological clock" for the working professional in her 30's. Which "big zero" are you approaching; 30, 40, 50? Is retirement a safe haven or a threat of emptiness? Many people seek therapy at critical transition points in their lives. The perspective of adult developmental tasks is one of the most powerful ways of understanding the context of current psychological distress.

Frequently issues surrounding loss are given additional power because they occur in an untimely manner. For example, the early death of a parent may produce an enduring sense of deprivation and of opportunities forever lost. The premature death of a spouse strikes to the heart of the bonding process. The early death of a child is one of mankind's most severe catastrophes, one that is forever actively present in memory. Man is the one animal that predicts the future. The theme of death runs through all great creativity: "to be or not to be."

Group termination has the power to stimulate these basic considerations of time. Fully acknowledging the reality of death and the inevitability of loss equips the therapist to address termination issues in a direct manner. It also helps as a corrective to the idea that one always has to do more, and guilt over not providing enough. The strategies developed in the present paper strive to turn the limitation of time into an opportunity to explore basic developmental themes. These focus on questions concerning the essential loneliness of the individual and the necessity of managing for one's self. The process of maturation is compressed into the time frame of the group. In short, the time-limited format presents an analog of the existential crisis (Yalom, 1980). For that reason, the question of time must be kept continually before the members.

For closed time-limited groups, the question of termination is determined in advance. The entire group experience is therefore conducted with the knowledge of exactly how much time remains. Time-limited group psychotherapy utilizes many techniques in common with group psychotherapy in general. Its uniqueness lies in the purposeful use of time to accelerate and concentrate the therapeutic process. The group and its individual members have the opportunity of pacing their psychological work within this time frame. The group process can be concentrated on fundamental themes elicited by the knowledge that the duration of therapy is finite. The group format provides an opportunity for the members to address such termination issues collectively.

TECHNICAL MANAGEMENT OF TERMINATION

There are a number of technical strategies that serve to keep termination issues clearly in focus for the therapist and for the group. Systematically implementing these techniques will provide a therapeutic frame within which termination can be effectively used as a major component of the time-limited experience. There has been increasing interest in the development of practice guidelines that outline basic therapeutic strategies. The following format can be seen in that light, as a protocol for the management of issues related to termination.

Selection of Members and Composition of the Group

Potential group members should be selected on the basis of their capacity to effectively use a time-limited group format. This will vary according to the objectives of the group. For highly structured and brief groups the need for careful selection is less acute and the termination process will have less impact. For example, psychoeducational groups may be quite helpful but are not intended to encourage group interaction except around the material being presented. For groups that are designed for intensive interpersonal work, greater care is required in member selection, particularly the capacity to move rapidly into psychological work and tolerate the stress of confrontation and the expectation of applied change. Piper and McCallum (1994) provide a thoughtful overview of selection criteria. The literature cited earlier concerning early premature termination also addresses selection and composition issues. This is relevant because in a closed time-limited group, the early loss of members may result in an excessively small group and present problems with

general morale. For that reason, many programs will admit additional members during the first three sessions if required.

The most salient composition issue is the level of psychological capacity members bring to the task (Klein, 1985). Three assessment dimensions may be helpful. Axis V of DSM-IV (APA, 1994) is a reasonable measure of overall functioning. Ratings of psychological mindedness and quality of object relations (Piper & McCallum, 1994) are more specifically useful. In practical terms, the result of these assessments is generally to think in terms of two levels of groups. For those with higher capacity, therapy will entail greater use of interpretive interventions and less structure, whereas those with lower capacity will benefit from a preponderance of structured and supportive techniques.

The importance of selecting members who are in the same general level of interactional capacity may be revealed at termination. A serious discrepancy in the ability to use the group format for effective change will become evident at that point. If some members are clearly in need of additional treatment, it may make it more difficult to deal directly with the termination of those who are appropriately completing treatment.

In addition to selection activities, the therapist should also strive to develop with each member a clear definition of what issues need to be addressed in the group (Budman & Gurman, 1988; MacKenzie, 1993). This may focus on mastering critical stress incidents, specific symptoms, interpersonal patterns, or addressing specific relationships in the past or present. The use of questionnaires that sample ideas about self and relationships are helpful to stimulate discussion of relevant areas. The results provide detailed feedback to the patient on how they describe themselves in terms of their important relationships from the past and the present (MacKenzie, 1944b). The nature of the goals will vary with the objectives of the group. It is most helpful to have members discuss their goals at an early point in the group. This procedure allows the group to form initially around universal material that is directly related to the tasks of therapy.

The process of engagement and early cohesion is further accelerated by composing groups on the basis of generally similar diagnoses or interpersonal problems or situations. For example, groups may be composed on the basis of all members dealing with early adult developmental issues (Budman & Gurman, 1988), or groups for people experiencing personal loss from death or separation (Piper et al., 1992). The basis for homogeneity may be more broadly defined, however. Psycho-

therapy deals with the endless combinations and permutations of a relatively small number of core themes focusing on issues of self definition and interpersonal functioning. These apply in varying ways to most situations in most age ranges. Members with quite varied characteristics and problems can therefore generally find a broad common group satisfactory for addressing their issues.

Decisions made in the assessment and composition process will have an impact on how rapidly the group can move into its task and achieve reasonable clinical change within a defined time limit. Getting a group off to a fast start means that there will be more time to spend in interpersonal work. This will increase the sense of bonding among the members and make the termination process more meaningful.

Use of a Closed Group Format

Time-limited groups may be either open or closed to membership changes. There are significant advantages to having the entire group begin and end together (Budman & Gurman, 1988; MacKenzie, 1990; Piper et al., 1992). This permits the application of a group developmental model (MacKenzie, 1994a). In a closed format, the group-as-a-whole moves through each stage together. This ensures that the therapeutic potential of each stage can be fully explored and exploited. The diversity within the group membership promotes an exploration of the inevitable resistance that will emerge when addressing group developmental tasks. A simplified developmental scheme is adequate for time-limited groups. This consists of an initial engagement stage, followed by a differentiation or conflict stage, which together equip the group for the third stage of more intensive interpersonal work prior to the termination stage. Time-limited groups spend most of their time getting formed and getting separated.

Each time there is a change in group membership, even the addition or loss of a single member, the group must renegotiate the balance of interactional forces in the system. This means that early engagement stage tasks must again be addressed. A group with a constant turnover of members will therefore have great difficulty in moving into more advanced interactional work. This may be appropriate if the goal of the group is to stay focused on collective tasks, such as learning psychoeducational material, or specific skills, such as assertiveness training or anger management. Some cognitive-behavior therapists will prefer to

keep the group at the engagement stage, whereas others will be interested in making fuller use of the interactional climate. Certainly groups planning to deal with interpersonal psychopathology will expect to move into more advanced group work. There is therefore a strong argument to be made for using closed groups with a predetermined time limit.

Many programs provide a time-limited experience using semi-open groups. These may expect an initial commitment from the patient to a certain number of sessions, say 10. The possibility of renewing the contract for a similar time period is provided. The result of this sort of arrangement is that the group must address termination issues at a relatively early point in group development and only for some members. This depletes the impact of the experience. Those remaining in the group must then incorporate new members and to do so will have to rework engagement issues once more. The result is that over both segments there is a significant restriction of time available to participate in more advanced group interactional work. A partially off-setting benefit is that the existing group culture may be more quickly transmitted to new members. It is not recommended that intensive time-limited group work be conducted under circumstances of constant membership change. The tasks of doing serious psychotherapy within a time limit are challenging enough without adding this extra burden.

Clarifying the Time Boundaries

The time frame of the group is specifically and clearly addressed during the assessment and preparation process. This is best done by providing the potential member with a written description of the group format that contains the date of the first session, the total number of sessions, the exact length of each session, and the date of the final session. Members are requested to review their calendars to be sure that all time clashes can be resolved. Members are also informed that a follow-up meeting will be scheduled approximately 4 months after the final session and that they are encouraged to refrain from seeking further treatment during that time period.

This amount of detail might seem at first glance to be excessive. It is important that there be no ambiguity regarding the dimension of time, however. This careful spelling out of time responsibilities also focuses the attention of the potential member on the need to plan his or her life around the work of the group. It encourages the member to think of the group as a circumscribed opportunity to work on important issues that must not be wasted. Evidence of resistance is often first shown in minor time boundary breaches. These can be addressed immediately, and nondefensively, if the groundwork has been carefully laid. An attitude of noncritical curiosity usually seems to work best.

Reinforcing the Time Frame

Most time-limited groups last for a period of 3 to 6 months. At the half-way point, that is session 8 of a 16-session group, the therapist makes a clear statement that the group has reached the mid-point and that 8 sessions remain until the last session on a specific date. This reminder is done clearly and firmly. It is accompanied by a suggestion that the group members take the opportunity of this middle session to review the course of their personal work to date. They are encouraged to describe their present sense of where they stand on issues that were initially considered important. Often, members use the session to recalibrate their therapeutic goals in view of their original objectives and what has transpired since the group began. This task reinforces the realization that the clock is ticking.

Following the midpoint time marker, an opportunity is found at each succeeding session to make reference to the session number or the number of sessions remaining. Thus a clear focus on impending termination is established from this point onward. Time-limited groups therefore spend the first half of their time becoming a working group as the eighth session usually coincides fairly closely to the accomplishment of the tasks of the first two group stages. The last half is then spent dealing with the implications of termination. This provides a sense of urgency and immediacy to the therapeutic process.

Maintaining a Focus

Throughout a time-limited group, the therapist will be as active as necessary to keep the members attention on the thematic material and goals identified at the time of assessment. Therapist activity may actually increase as the group moves into more intense interpersonal work in the last half of the sessions. This does not mean that the therapist controls the group process. The function is one of maintaining a thematic focus and encouraging broad participation in this from all group members.

Much of this work can be done by simple reinforcement or minor encouragement. This is an opportunity to maximize the learning potential of the here-and-now group experience by identifying behaviors or experiences that are related to key focal issues as they emerge in the group interaction. The nature of this work on personal themes will merge into termination themes, often with considerable overlap. The therapist should be alert to subtle evidence of termination anxiety. This may be lurking under the surface in discussions about managing without important others, or dealing with loss or separation. Much of this work of historical integration within the group experience is likely to be done by the group members with the therapist being prepared to underline and punctuate the material.

The final few sessions frequently provide an opportunity to address long-standing themes in a powerful manner because of the knowledge of the termination date and the attendant emotions contained therein. The attention to original the thematic focus therefore continues through the final sessions hand-in-hand with termination issues. In preparation for the final few sessions, the therapist needs to consider if the original goals of each member were realistic and whether the scope of work can be intensified or needs to be contained. Any tendency to collude with patient resistance must be carefully avoided. The therapist must be comfortable dealing with powerful and evocative areas even if only two or three sessions remain. It is for this reason that a positive attitudinal posture toward the implications of time is important.

Forestalling Premature Termination

At the fourth session from the end, the therapist introduces the idea of premature termination. This is done in a straightforward manner as follows. Reference is made to the date of termination. The rationale is presented that dealing openly and directly with the forthcoming end of the group may be uncomfortable or difficult. Sometimes the thought arises that it would be easier to simply stop before the final sessions. This is seen as an understandable idea to have. However the group started together, has worked together, and it is important that it end together. Has anybody indeed considered premature termination? Bringing the topic directly into the open in this way is a useful preventive strategy. Most groups have some members who have wondered about this way of avoiding the end. The ensuing discussion usually results in a constructive

review concerning termination matters and clearly marks the final phase of the termination process. The remaining sessions are viewed primarily through the lens of termination.

This simple technique of formally predicting premature termination also ensures that the therapist does not avoid the impending end of the group. Therapists are subject to the same issues as the members concerning the question of separation and loss. The members are able to share these matters with each other and this may create a sense of isolation and deprivation for the therapist. This can result in a sense of pessimism about the effects of therapy and perhaps an emotional shutting down that will subtly impede the group process.

Termination Themes

The most important therapeutic task involves the exploration of several strategically important termination themes. These themes will be found in most termination circumstances but are particularly powerful when a cohesive interactive group environment has been created. Note that this material will be found, and should be addressed, in both supportive and interpretive groups. The therapist should assume that such material will be found within the reactions of members to the impending termination, even if not put directly into words. The therapist's task is to ensure that all of the themes are verbalized and confronted and the therapist must be prepared to be active in directing attention to them.

The early termination work often centers around the belief that not enough time is available, that the members have not got as much as they would like from the treatment program. This theme of deprivation is often introduced with an affect of sadness or hopelessness. The group may move into strong universalization mechanisms with this material, a temporary regression in level of group functioning. This may take the form of requests for additional sessions or private interviews. It is useful to promote this resurgence of group cohesiveness as a counterbalance to the disintegrating forces of termination. This presents the group with the paradoxical situation of becoming closer as they discuss separation.

The theme of deprivation may have important outside connections for members. Often this entails the belief that they received inadequate or damaging parenting. The therapist is seen as replicating that experience. This may activate themes of abandonment, which the member experiences as a deep sense of disappointment, even nihilistic despair at

not getting enough nurturance from parents. "How can I be whole now, since I received so little then?" Often connections can be made to the issues identified at the beginning as being important goals. For example, difficulty with low self-esteem and a pattern of being exploited in relationships may be connected to the childhood fear of total abandonment if any word of disagreement or complaint was uttered. An open discussion of the member's dissatisfaction with the ending provides an opportunity to reverse that negative belief.

The most effective technique for dealing with concerns about inadequate time is to simply accept that the members are experiencing difficult reactions to the impending end of the group. A matter-of-fact reconfirmation about the duration of the group may be made. It may also be useful to draw the analogy between the sense of not having got enough out of the group just as one lives with the idea of not having got enough out of life. Statements addressed to the whole group may assist in building the momentum to address such themes. The philosophical attitude toward the importance of time described earlier in this paper may be of value to the therapist at this point. It is important that the therapist not demonstrate verbally or nonverbally any sense of guilt or apology that more time is not available. A steady course is best that reaffirms that the group is talking about important experiences even though relatively little time remains.

This theme of deprivation bring with it undercurrents of resentment and anger: "if they didn't have these strict rules about service limits"; or "I suppose you always herd patients through these groups so quickly" or "I have been thinking about finding an individual therapist this week." The therapist needs to be attentive to the theme and feel confident in bringing it into a discussion of this group and this therapist. Once again the principal therapeutic guideline is to tolerate, accept, and encourage such ideas. The angry underside of the theme of deprivation brings with it energy and constructive possibilities. These almost inevitably lead to a more balanced view of the importance of continuing the personal work begun in the group after termination. The therapist may indeed be quite explicit that such is anticipated and that it routinely evolves for most patients.

Within the deprivation material, there may be an important subtheme of rejection. This is often directed at a core sense of unworthiness. "I am always rejected (in friendships, marriage, work, social organizations) because of the sort of person I am." This powerful core belief may

have a major role in distorting all aspects of interpersonal adaptation. It is important that it be clearly expressed in the group and that responses from others are solicited. Such statements should never be allowed to go without a response before the session ends.

Another powerful theme inherent in the termination process is that of loss, a grief analogy. It is common for distant losses to again come into awareness. This may reveal areas of unresolved grieving. It is an opportunity to speak unspoken last words. Not surprisingly, these often contain the same ambivalent mixture of sadness and resentment that is being experienced in the group itself. At first hand, one might have some reluctance in opening up new material of this nature with only a small number of sessions remaining. The force of the group atmosphere encourages discussion of such material, however, sometimes the first time it has been openly expressed. The opportunity of doing this in the public arena of the group and receiving an understanding and encouraging response helps to facilitate a sense of personal mastery over the historic situation.

A final common theme centers around the necessity of managing for one's self. This is a powerful existential message. The therapist may reinforce this idea by actively pursuing what it will be like not to have the group to attend in future weeks. It might be mentioned that most patients find that they make further gains during the months after the group ends. The therapist should not attempt to palliate the theme by any reference to the planned follow-up session, however.

It will be clear at this point that all of these themes have a direct connection with self-esteem. By forcing an open discussion of this material, the therapist is also forcing an examination of attitudes toward self. These connections need to be reinforced if they are not expressed directly and clearly. The intent of this focusing strategy is to promote an increased sense of self-efficacy. The time limit of the group becomes a direct challenge to such beliefs. The implicit message is that the therapist and the group anticipate that the members will manage and will continue to accomplish further self-improvement goals.

The Last Session

The last session always seems to begin with new and important material. The therapist must avoid temptation to pursue this. Making a virtue out of necessity, one might say something like "it sounds like you are be-

ginning to focus on some important issues to work on over the next few months." The final session returns to a modest degree of structure. This is similar to the first session when members were asked to make an extended opening statement regarding the issues that emerged as critical for them during the assessment process. The impact of the ending will be strongest for groups that have achieved higher levels of interaction and cohesion. The following format may be abbreviated for groups that have had a less interactive focus.

Most of the final section is devoted to a systematic go around in which each member speaks directly to each other member. For a group of eight members, this usually requires 45 minutes at the very least. The therapist always feels in a bit of a bind with regard to timing. One needs to make sure that there is sufficient time to accomplish the assigned task. On the other hand, it is helpful not to finish the task with too much time remaining in the session. In general, allowing a good 5 minutes for each member seems about right. It is important that the therapist not let the first few parting statements take up too much time so that the final ones must be rushed. If necessary, the session may need to be extended slightly.

Members are encouraged to view this as an opportunity to say things they would like to have said to each other but had not had the opportunity. Identifying specific critical events between themselves and another member is common. Specifically using such phrases as "good-bye," "the end," "it's over," "I shall miss seeing you," "next Wednesday will seem empty" are encouraged. This is clearly an analog process to expressing final words to deceased.

The group process for this final go around focuses on one member at a time. The sequence of participation is left up to the members. There is encouragement to take this as a serious opportunity to deal with the process of separation and to bring to a firm conclusion the various relationships that have been developed in the group. This exercise virtually always results in powerful reinforcement of the importance of the group and as a support for self-esteem. At the same time, the structure helps to contain and channel the level of expressed affect.

The comments often deal with how another member served as an important model or an inspiration to try something new. Often advice that was helpful is recalled. This is a reminder that therapy groups are filled with ideas, suggestions, and advice whether or not the therapist thinks this is a good idea. Often specific critical incidents in the group's life are reviewed. Most of these center around an experience of confron-

tation or anger that was worked through. Sometimes they refer to powerful bonding experiences that took place early in the group. Members often talk of their hope for others as they address issues that were not fully explored in the group. This is a nice reinforcement for the idea of continuing personal psychological work after the group ends.

Generally the therapist is included in these comments. Here one experiences the same sense of mild apprehension and careful listening that each member has when he or she is specifically addressed by the others. As a general practice, it is best for the therapist to avoid making specific comments to each member. This would invite highly sensitive comparative evaluations that are unnecessary. The therapist does better to make general supportive and empathic comments to the whole group. It is useful to be sure to position oneself so that a final good-bye can be given to each member as he or she departs. A handshake or a hug is a social symbol of termination.

It is common during the final sessions for members to talk of reunion. Often phone numbers are exchanged and tentative plans put in place. In general, such efforts do not come to fruition. Because the therapist has no power, nor right, to restrict what happens after the group ends, such plans are best treated with benign neglect. The focus continues on addressing termination issues in the belief that if these are adequately worked through the need for maintaining the illusion of the group will automatically subside. During the follow-up meeting described below, there is an effort to determine what contacts have actually taken place. These are usually restricted to a few phone contacts, if that.

At the very end of the final session the members are reminded that they will be contacted for an individual follow-up visit in about 4 months time. They are encouraged to use this time to continue the work begun in the group and not seek further active treatment. The follow-up visit is described simply as an opportunity to see how things are going and to check if anything further is required. Although not put specifically into words, this visit clearly acts as an inducement to continue working on issues raised in the group in order to demonstrate to the therapist that the members have the capacity to achieve further progress.

The Follow-Up Visit

The 4-month time period is based on outcome literature indicating that improvement following psychotherapy continues at a substantial rate for

several months. The 4-month visit is designed to catch this process at its peak. Some programs have used another group meeting for this follow-up contact (Budman & Gurman, 1988). However, an individual visit avoids fostering the idea of the continued existence of the group, which might undermine the termination message.

The visit is not defined as, nor conducted as a formal therapy session. It begins with a general discussion of how the patient has been managing in the 4 months since the group ended. This material is reviewed in terms of the issues raised as objectives before therapy began and in the light of learning experiences that occurred during the group process. A generally cognitive stance is maintained. It is useful to reinforce those areas of accomplishment that the patient may underplay. Often the therapist will be able to note shifts in self-esteem or relationship dimensions that the patient has not quite appreciated. Areas that continue to be problematic can be reviewed in a brief fashion to clarify what they entail. The general approach is to foster an attitude of self-sufficiency. On occasion, significant difficulties require referral for further formal treatment although this is not a common occurrence. It is more likely to have a patient return 1 or 2 years later often with quite a new set of issues to address.

REFERENCES

Alexander, F., & French, T. M. (1980). *Psychoanalytic therapy: Principles and application.* Lincoln: University of Nebraska Press. (Original work published 1946)

American Psychiatric Association (1994). *Diagnostic and Statistical Manual,* fourth edition. Washington, DC: American Psychiatric Press.

Bauer, G. P., & Kobos, J. C. (1987). *Brief therapy: Short-term psychodynamic intervention.* Northvale, NJ: Aronson.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

Bernard, H. S. (1989). Guidelines to minimize premature terminations. *International Journal of Group Psychotherapy, 39,* 523–529.

Budman, S. H., & Gurman, A. S. (1988). *Theory and practice of brief therapy.* New York: Guilford.

Connelly, J. L., Piper, W. E., de Carufel, F. L., & Debbane, E. G. (1986). Premature termination in group psychotherapy: Pretherapy and early therapy predictors. *International Journal of Group Psychotherapy, 36,* 145–152.

Crits-Christoph, P., & Barber, J. P. (1991). *Handbook of short-term dynamic psychotherapy.* New York: Basic Books.

Davanloo, H. (1980). *Short-term dynamic psychotherapy. New York: Jason Aronson.*

Dies, R. R., & Teleska, P. A. (1985). Negative outcome in group psychotherapy. In D. T. Mays & C. M. Franks (Eds.), *Negative outcome in psychotherapy and what to do about it* (pp. 118–141). New York: Springer.

Fieldsteel, N. (1990). The termination phase of combined therapy. *Group, 14,* 27–32.

Foulkes, S. H. (1975). *Group-analytic psychotherapy: Method and principles.* London: Gordon & Breach.

Freud, S. (1963). Analysis terminable and interminable. In P. Rieff (Ed.), *The collected papers of Sigmund Freud: Therapy and technique* (Vol. 3, pp. 233–271). New York: Collier. (Original work published 1937)

Garfield, S. L. (1989). *The practice of brief psychotherapy.* New York: Pergamon.

Gustafson, J. P. (1986). *The complex secret of brief psychotherapy.* New York: Norton.

Hollon, S. D., & Shaw, B. F. (1979). Group cognitive therapy for depressed patients. In A. T. Beck, A. J. Rush, B. F. Shaw, & G. Emery (Eds.), *Cognitive therapy of depression* (pp. 328–353) New York: Guilford.

Klein, R. H. (1985). Some principles of short-term group therapy. *International Journal of Group Psychotherapy, 35,* 309–330.

Klein, R. H. (1993). Short-term group psychotherapy. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive group psychotherapy* (3rd ed., pp. 256–270). Baltimore: Williams & Wilkins.

Klerman, G. L., Weissman, M. M., Rousaville, B. J., & Chevron, E. S. (1984). *Interpersonal psychotherapy of depression.* New York: Basic Books.

Lothstein, L. M. (1993). Termination processes in group psychotherapy. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive group psychotherapy* (3rd ed., pp. 115–124). Baltimore: Williams & Wilkins.

MacKenzie, K. R. (1990). *Introduction to time-limited group psychotherapy.* Washington, DC: American Psychiatric Press.

MacKenzie, K. R. (1993). Time-limited group theory and technique. In A. Alonso & H. I. Swiller (Eds.), *Group therapy in clinical practice* (pp. 423–447). Washington, DC: American Psychiatric Press, Inc.

MacKenzie, K. R. (1994a). The developing structure of the therapy group system. In H. S. Bernard & K. R. MacKenzie (Eds.), *Basics of group psychotherapy* (pp. 35–59). New York: Guilford.

MacKenzie, K. R. (1994b). Using personality measurements in clinical practice. In P. T. Costa & T. A. Widiger (Eds.), *Personality disorders and the five-factor model of personality* (pp. 237–250). Washington, DC: American Psychological Association.

Malan, D. H. (1979). *Individual psychotherapy and the science of psychodynamics* (2nd ed.). London: Butterworth.

Mann, J. (1991). Time limited psychotherapy. In P. Crits-Christoph & J. P. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 17–43). New York: Basic Books.

Mann, J. & Goldman, R. (1987). *A casebook in time-limited psychotherapy (1982).* Washington, DC: American Psychiatric Press.

Piper, W. E. & McCallum, M. (1994). Selection of patients for group interventions. In H. S. Bernard & K. R. MacKenzie (Eds.), *Basics of group psychotherapy* (pp. 1–34). New York: Guilford.

Piper, W. E., McCallum, M., & Azim, H. F. A. (1992). *Adaptation to loss through short-term group psychotherapy.* New York: Guilford Press.

Rank, O. (1973). *The trauma of birth.* New York: Harper & Row. (Original work published 1929)

Roback, H., & Smith, M. (1987). Patient attrition in dynamically oriented treatment groups. *American Journal of Psychiatry, 144,* 426–431.

Rose, S. D. (1989). *Working with adults in groups: Integrating cognitive-behavioral and small group strategies.* San Francisco: Jossey-Bass.

Rutan, J. S., & Stone, W. N. (1993). *Psychodynamic group psychotherapy* (2nd ed.). New York: Guilford.

Ryle, A. (1982), *Psychotherapy: A cognitive integration of theory and practice.* London: Academic Press.

Shapiro, D. (1989). *Psychotherapy of neurotic character.* New York: Basic Books.

Sifneos, P. E. (1987). *Short-term dynamic psychotherapy* (2nd ed.). New York: Plenum.

Yost, E. B., Beutler, L. E., Corbishley, M. A., & Allender, J. R. (1986). *Group cognitive therapy: A treatment approach for depressed older adults.* New York: Pergamon.

Yalom, I. D. (1980). *Existential psychotherapy.* New York: Basic Books.

Yalom, I. D. (1995). *Theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.

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Limiting Time-Unlimited Group Psychotherapy

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ABSTRACT

For a number of reasons, we decided to bring three long-term, open-ended psychodynamic therapy groups to termination. We examine the process that began with the announcement of the change to a time-limited format, and concluded with the termination of the group. The transition had a powerful impact on the members and the group-as-a-whole. The therapists used supervision to deal with the intensity of the group process and the countertransference demands posed by the transition. Groups facing a similar change due to economic pressures may benefit from these observations.

This article addresses the clinical issues associated with the decision to limit time-unlimited psychotherapy groups. The decision in our clinical setting was influenced by a number of factors. The summer of 1992 marked the onset of a major restructuring in our acute care university hospital. Our outpatient psychiatric service faced a 20% cut in staffing.

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