Group Psychotherapy with a Homogenous Group of Suicidal Persons

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Summary - Abstract

Group therapy with a homogenous population of suicidal persons has only recently been reported in the literature. It is the authors' hope that by recounting their experience in developing and leading such a group, they may facilitate similar endeavors. Planning and preparation are stressed and the necessary initial steps are outlined for starting such a group. Nearly two years of experience with the group are described, including handling of several crisis situations. The group is limited to severely depressed and suicidal persons and all of the members have made at least one suicide attempt. The group is open-ended and meets weekly at a community mental health center for $2\frac{1}{2}$ evening hours. Various treatment modalities are utilized, but the group also functions as a social club. The group offers depressed and suicidal persons first and foremost unconditional acceptance, an emphasis on understanding depression, and a framework in which they feel worthy of love and gradually learn to risk expressing anger and other negative feelings without an accompanying loss of self-esteem. In the group depressed and suicidal persons no longer feel that they are alone or unique. The group offers concern, interaction, and interpersonal relationships that carry over into the members' lives outside the group. The group has had 35 members during the first 22 months. There has been only one suicidal gesture and one suicide attempt and no suicides since we started the group in September, 1971. We believe that this type of "suicide attempters anonymous" group is an effective means of suicide prevention.
Introduction

It seems clear that emphasis in the field of suicide prevention is shifting from identification and assessment of the suicidal person toward developing more effective treatment methods. One of these, in limited use, has been group therapy with suicidal persons. Previous experience over the past four years with two such groups based at the San Francisco General Hospital has proved group therapy to be an effective means of suicide prevention [11]. These groups have dealt primarily with recently discharged inpatients and outpatients, mainly from the downtown and lower socioeconomic areas. Nearly two years ago we (D.H.R. and C.A.) started a new group that is markedly different in that it is located in a community mental health center outpatient department and draws its patients primarily from a stable middle class residential area.

We have found group therapy to be a logical treatment modality for depressed and suicidal persons for several reasons: (a) the problems of alienation and loneliness and the need to feel accepted and be part of a uniting and supporting relationship lend themselves well to group treatment; (b) patients look to each other for role models and become useful to each other through powerful peer feedback; (c) the therapists tend to be seen as more human and real, facilitating the process of identification; (d) transference phenomena are multiple and quantitatively much richer than in individual treatment; and (e) more persons can be reached and potentially helped than with other methods.

There are few previous reports of group therapy with suicidal persons [2–8] and none of these focused on the problems of getting a group started. Why is there such a paucity of group therapy programs? Is it because of our own anxiety about working with a group of high risk patients? Perhaps part of the reason is the newness of both suicide prevention and the group treatment of suicidal persons. Another reason might be that therapists are not certain of how to begin such a group. It is our hope that our account of our experience both in starting and in working with a group of suicidal persons for nearly two years may facilitate other such endeavors.

Preparation for Starting a Group

Before actually starting our groups for suicidal persons, certain basic questions had to be answered. These fell into four general categories: (1) What did we have to offer? (2) What would be the goals and objectives of our group? (3) What population would we draw from? and (4) How would we actually set up such a group?

What did we have to offer? We wanted to work with a group of suicidal patients and, following an assessment of our limitations and strengths, we felt we could handle the anticipated emotional stress, especially in regard to the extreme dependency needs of suicidal persons.

What would be the goals and objectives of our group? Our goals were suicide prevention, understanding depression, and helping people through depressive and suicidal episodes, thereby helping them to develop the resources to deal with subsequent suicidal episodes. We planned to encourage appropriate expression of anger, to interpret the aggressive component in the suicidal wish, to foster acceptance and demonstrate concern and facilitate socialization and support.

What population would we draw from? We chose hospitalized patients with the history of a suicide attempt.

How would we actually set up such a group? We chose to work with cotherapists, under the auspices of the community mental health system. Our groups would be open-ended with voluntary participation and served as both primary and adjunctive forms of treatment.

Most of the above questions should be answered and the details worked out before seeking the needed cooperation from your colleagues. When you announce your special interest in such a group, you may hear that you are implying you can successfully accomplish what few others have been able to do, namely prevent suicides, and it is well to be prepared for much resistance on the part of others when discussing this method of dealing with such a high risk population.

Starting a Group

The first step was defining what we wished to do and accepting the limitations involved in realizing these objectives. The initial planning took us about three months, after which we approached one of the administrative staff members of our Institute with our proposal. The response being quite positive, we set a tentative starting date for the following month.

The next step was to select prospective group members. We initially recruited from inpatient services, and this process was facilitated by one of us (C.A.) having clinical-research exposure to a large inpatient population. We decided to accept into the group persons whose typical reaction to stress included depression and suicidal behavior. However, we have accepted only those who have acted on their suicidal thoughts or impulses. The invitation that was (and is) extended to each prospective member conveyed two messages: (i) the supportive nature and (ii) the flexibility and openness of the group.

We then proceeded to what we thought would be the final step in the process of starting a group, that is locating physical space in which to meet
and obtaining formal sanction from the administrators of our Institute. We experienced this last step as one of public relations and it was to be the most challenging one to our interest and enthusiasm. We had been advised to serve under the Institute's outpatient department as an adjunctive form of treatment rather than as a primary mode of therapy, and to leave the responsibility for any needed additional clinical care (i.e., medication, individual therapy, hospitalization) in the hands of the individual primary therapists. Accordingly, we submitted our plan to appropriate staff and soon realized that our proposal was to be heavily weighed and considered. Our starting date was revised. The critical review of our proposal questioned the need for such a special interest group and cautioned us about the implications for outcome of working with a group of suicidal persons. Our proposal was received as much more controversial than we had anticipated. In view of the logistical difficulties encountered at this point, we decided to approach the district community mental health center. Fortunately, the director of the center was enthusiastic about our objectives and helped facilitate the staff's acceptance of our plans. The details finally worked out, we began our group therapy meetings in the Fall, six months after the inception of the idea.

Our decision was to maintain an open-ended group made up of voluntary members participating on an outpatient basis following hospital discharge. Our group meetings are held once a week for two and one-half hours. We have received referrals from mental health workers both at our Institute and at community mental health facilities, from private therapists and from various community resources. We began as an adjunctive therapy modality, accepting only persons who had individual therapists, but found within a few short months that we were functioning (with the sanction and encouragement of the mental health center) as a primary treatment modality. However, we still encourage group members to be in individual therapy and two-thirds of the members are in individual psychotherapy. We have had thirty-five members in our group to date. The members' time investment has ranged from two to seventy-five weekly sessions, with the average number of weekly sessions per member being seventeen. We have found that referrals are increasing at a pace faster than we can comfortably accommodate, and we are now in the process of planning a second group at the Institute for suicidal persons.

**Epidemiological Characteristics of the Group — An Overview**

Of the thirty-five members in our group over a period of ninety-five weeks, twenty-two have been women and thirteen have been men. The age range has been from eighteen to sixty years, with an average age of thirty-six years. Twenty members are single, eight divorced and seven married. Occupations include: nurses, research assistants, a barber, a construction worker, artists, a comptometer operator, a salesman, a real estate broker, teacher, inhalation therapist, students, housewives and several unemployed. Diagnoses varied and included eleven endogenous (psychotic) depressions, eighteen reactive (neurotic) depressions — these included also personality disorders, and six schizophrenic reactions with depressive and suicidal features. A number of the members have a history of repeated suicidal behavior, including one man who has made six serious suicide attempts and one woman who has made five serious attempts. We have had two members whose suicidal behavior is more aptly described as gestures that intend to influence others in a manipulative way, and these have presented a very low suicide risk. The remainder of the group members varied in their suicide risk, and included ten high suicide risks, fifteen moderate risks and eight more low suicide risks. Of our total referrals, only five had been treated on an emergency service for a suicide attempt and not hospitalized, while twenty had a history of more than one psychiatric hospitalization and four have had electroshock therapy. The size of the group at any given time has varied from five to thirteen, the average being nine group members. We are pleased to report that to date we have had no suicides, one suicide gesture which the member reported by coming straight to the group meeting, and one suicide attempt by a member who had not attended the group for more than a month.

**Course and Development of the Group**

The first meeting was very awkward. We (the two therapists, D.H.R. and C.A.) arrived fifteen minutes early and wondered if any of the seven invited patients would come. Three patients came, and they too were anxious about starting the new group. Once we began, much of the time was spent with introductions and explanations of what we (the cotherapists) thought the group's purposes and objectives were. We discussed the open-ended policy (come when you want to and for as long as you wish). We talked about the importance of sharing feelings regarding present and past life experiences, with a focus on exploring why members became depressed and suicidal. We emphasized the need to understand suicidal behavior as symptomatic of underlying problems of loneliness, feelings of hopelessness, worthlessness, and unresolved conflicts. We provided some didactic information about what depression represents, with special emphasis on anger and guilt. We explained that we saw the group as offering unconditional acceptance and a framework in which members would feel worthy of love and esteem, where they could reveal negative and angry feelings and realize no resultant rejection or loss of self-esteem.
The three persons who attended the first session voiced their own expectations, stating what they hoped to gain from the group. One member asked almost kiddingly if the group could promise her a „cure“. Another member thought the group would help her stay undepressed. One person questioned the therapist’s position, saying (to one of the cotherapists), „Doctors are nonentities, and I don’t like being dependent on them“. In addition to the dependency issue, other themes of trust and of questioning peers were prominent.

Near the end of the meeting we asked the members to share their feelings and thoughts about the group and each other. One patient questioned the purpose of the group and thought it would be depressing for her to talk about and hear about depression, week after week. She stated she felt like throwing something — but was glad she came and was able to talk about her feelings. By the end of the meeting we felt a common bond that we hoped would set the stage for a cohesive group. At the end of the session we said we would look forward to seeing them again next week. Our first meeting was held in a small room that had no windows; it was cramped and closed-in, with no pictures on the walls. We decided to meet next time in the front waiting room, which was comfortable, well lighted, spacious, with windows and colorful paintings on the walls (this room continued to be our meeting place).

As the sessions progressed our initial awkwardness and anxiety dissipated and we experienced definite „growing pains“ over the first several months, starting with some resistance and distrust of each other and ambivalence about opening up. We moved on to sharing past life experiences and painful feelings. Some catharsis and crises occurred in relation to emotionally laden problem areas, and we developed a stable core group (which included the initial three members) with a greater degree of trust and mutual affection for each other. The following is a typical example of a crisis situation:

A mother of three young children, upset over having to have all of her teeth extracted within a few days, said she was planning to kill herself. She was tremulous and emotionally withdrawn from the group at times. She felt things were crumbling around her. She was angry with her family and with one male group member because of something he had said to her the week before. She was very self-critical and wanted to inflict pain on herself. She asked the female cotherapist if she wanted to hit her and then proceeded to burn herself superficially with a cigarette. She yelled out that she hated us and that she did not need us and could do it all on her own. The group showed much concern for her and we talked about dependency needs, the fear of rejection, and the guilt one feels when expressing anger. The question was raised of how we could help each other in time of need, of emotional turmoil, and the group decided to exchange telephone numbers in order that they might call each other if feeling suicidal or feeling as if they could not handle a situation. The upset member felt she probably would not call anyone because she might bother them, and one member quickly invited her to call or „bother“ him, saying he would welcome a call in time of need. The group ran necessarily past the usual two and one-half hours, all members feeling uneasy about the one’s acute depression and self-destructive impulses. She remained after the group broke up and expressed to the cotherapists a fear of going home. She sat with us for a short period, and we talked with her, offered her support and reassurance until she felt comfortable enough to go home.

During the fourth and fifth months, we entered a working as well as a socializing period. A sense of cohesiveness allowed for working through problems and for corrective experiences of learning not to act on impulse but to recognize and reflect on one’s behavior. Nevertheless, during this period a common problem was that of accepting new members into the group.

The appearance of a new member generates responses varying from enthusiasm to disillusionment. The members often project their fantasies and expectations onto the new member. Sibling rivalry transference patterns are activated and angry reactions are displaced onto the vulnerable and passive group members. Sometimes members who have been in the group for a long time will try to get rid of a new member by direct attack, expressing feelings of superiority or of anxiety or exaggerated concern. Once a regular male member told a new member he felt hostile to her because she „took the spotlight away“ from him and other members.

One of the benefits of group therapy with suicidal and depressed persons is that transference is diluted because of the multiple transferences generated out of the familiar/familial atmosphere of an open-ended and continuing group. This is important since working with these patients in individual sessions can be very emotionally taxing.

The open-ended nature of the group allows for the continuous opportunity of meeting and accepting new people, encourages members who might otherwise find it difficult to seek help at crisis times, to return whenever they feel a need, and for dealing with the issue of separation. The „deathbirth“ theme has often occurred in the group. An example of this happened when the male cotherapist announced he was leaving the group. A female member fantasized the death of her only son and imagined that she was pregnant. When the cotherapists have left for vacations, members have developed all kinds of fears (such as the fear of having cancer). Usually these fears are based on what has happened to them in the past or how they managed to cope when important individuals left them. Some members feared the cotherapists would die (many of the group members have lost parents by death at early ages). The open-ended group is a continued growth-oriented experience, and we have gone through several four-to-five month cycles of the following phases:
1) resistance-building trust ("getting to know one another");
2) sharing and repeating past behavior (catharsis and crises);
3) action and resolution (working and socializing together).

During the initial phase of resistance, members are reluctant to open up because of past experiences of being hurt and rejected. Suicidal and depressed persons feel worthless, hopeless, and alone. They erect walls around themselves. They feel unworthy of love or acceptance. They are usually in an isolated world of self-hatred in which death seems a welcome way out. Much resistance breaks down over time with didactic understanding and with the help of the accepting, loving, and caring environment of the group. Didactic material includes discussing the role of rage in the etiology of suicidal and depressive states, anger and anxiety and defenses against these, the learned repression of anger and rage and how this can lead to symptoms such as intense psychic pain, agitation, and insomnia. Building trust comes from overcoming the initial resistance to self-scrutiny and criticism, exploring the causes for past depressive and suicidal episodes, and beginning to share past life experiences and present feelings. There is a focus on who the individual is angry at or what situation or fate has enraged the person. It is a difficult process of unlearning old self-destructive patterns. One member could not believe that any of the group members liked or accepted her because she hated herself so intensely. She lashed out at the member who loved and cared for her the most by sending her an anonymous poison pen letter. She later told the group that she had done this and was puzzled that the recipient of the letter was angry at her but still accepted and liked her as a person. She wanted this member and the whole group to scream at her and she thought we really resented and hated her. She thought the recipient of her letter was like her mother, falsely loving her but secretly hating her. The other member simply said, "I'm not your mother and I really do like you". Following this her resistance began to lessen.

This example shows an overlap with the second phase, that of sharing and repeating past behavior. This is a phase of expressing feelings, a period of catharsis and crises. In order to facilitate change, members begin to examine repeated past conflicts and their previous solutions during this phase. And as a result members sometimes become acutely suicidal. During this period much repressed anger and rage are expressed. We feel it is important to note that the ventilation of intense feelings alone does little more than provide temporary relief, and may even do harm. Members may be left shaken, vulnerable, and unable to accept the group's support and reassurance. As outlined by Billings et al. [11] it is crucial that three elements be present in order that therapeutic benefit may be realized from the catharsis of threatening angry feelings. These elements are: 1) The member needs to become consciously aware of being angry. If the person is denying that he is angry, little headway will be made. We have found that the senior group members can facilitate and aid newer members to focus on and identify painful feelings. They might say to the new member, "If that had happened to me I sure would feel angry." 2) We believe it helps if the person can become acquainted with the threat that anger presents and the defenses used to prevent awareness of the anger. Common for our group members is experiencing a constant threat of rejection or loss of love and esteem if negative feelings are expressed; this threat is manifested by feelings of anxiety and emotional discomfort and we have found this approach to identifying angry feelings quite helpful. 3) The most important element is that the person actually feels no threat of rejection or loss of esteem in the group atmosphere. This requires the fostering and maintenance of a sincere, honest, consistent, and caring atmosphere which attempts to convey a feeling of unconditional acceptance. The messages we attempt to relay are: "You may do and say things I don't like but that does not mean I don't like you". "Your feelings are valid and you have a right to feel as you do." "There is much more to you than what you say or express." "I will be as honest with you as I can be."

Through this sharing of negative feelings and realized acceptance it is hoped that the members will allow themselves to believe others' positive feelings about them, and will realize that angry and intimate feelings (hate and love) are closely related opposites of the same coin. Under these conditions, when emotionally laden buried material comes out it may be dealt with in such a way that the patient is assured that his or her feelings are o.k. and that he or she is o.k. It can be readily seen that this is a process of behavioristic deconditioning and represents the unlearning of old destructive patterns and replacing them with constructive patterns that carry over from the group into the world at large. Through insight obtained in phases one and two, the group passes into a third phase of action, where change and resolution are characterized by a working and socializing period. It allows for working through problems and for corrective experiences of living and of learning not to act on impulse but to recognize and reflect on one's behavior. It is characterized by work, a sense of intimacy and of socialization.

Discussion

The group process with depressed and suicidal patients is similar to "the porcupine dilemma" [9]. Schopenhauer tells the story of several chilled porcupines huddled together for warmth on a cold wintry day. They found they pricked each other with their quills and moved apart and were cold again. After much experimenting the porcupines discovered the optimal distance at which they would give each other some warmth without too much sting.
We have found the telephone to be a useful tool. As described above, it was introduced by patient suggestion at a time of crisis. We all share our home telephone numbers (this is an example of the concern we have for one another, which extends beyond ordinary group therapy practices). Patients call each other or the cotherapists when severely depressed or suicidal. It has not been abused and is infrequently used. The telephone is used for follow-up if group members are concerned about other members who have missed meetings. And it has also been used to contact primary therapists regarding patients in suicidal crises.

When the group is in a socializing period (usually every four to five months) we have group dinners and informal parties. These are characterized by openness and friendliness. Around the holidays and members' birthdays we also have informal social functions after group meetings.

In working with a group of this kind, we frequently are exposed to the intimate experiences associated with death and the threat of death and feel its accompanying anxiety. We find the work with suicidal patients at times emotionally taxing, and having a cotherapist is a great advantage. Cotherapists support one another, provide continuity, allow for model relationships with two different personalities, and male and female leaders provide for parental and sibling transference.

Our group is very "group" centered and as cotherapists we are participants as well as leaders. When we start each group meeting, we all indicate how we are and how we are feeling at the moment (as leaders we do share our feelings but we never burden the group with our own personal problems).

The open-ended group lends itself well to work with suicidal persons. They come when they want and need to and there are no guilt feelings if they miss a meeting, because they have broken no contract. It is especially useful for starting groups, as you can begin with only a few patients and add new patients from time to time.

We have found it valuable to caution depressed and suicidal patients regarding the ups and downs of getting well. They experience "feeling good" as a ray of hope and as some light at the end of the tunnel, only to have it disappear suddenly after a stressful event or an interpersonal disappointment. This downward fluctuation often is interpreted by the patient as meaning that he is right back where he started, at the bottom of an abyss. Actually the patient is not at the bottom again but is probably going through a less intense depressive episode. Since many suicides occur during these periods, we feel it is crucial to let the recovering depressed or suicidal person know that he can expect "down" periods in the future that will pass in time. We stress that he might feel that he again is at the bottom when actually he is not and that he is not alone in this experience.

We have come to realize the group's inherent maturational and curative properties. We have found it to be a unique and profound experience to work with suicidal persons. These patients all have been so close to death that they seem to have a great awareness of life and its pain in the "here and now". There is a true sense of intimacy and acceptance among the group members and we have found these people enjoyable to work with. We talk openly about suicide as an option that is available to the individual member, but we always focus on other options and alternatives to life's problems. An example of this is the group helping a suicidal member who was plagued with impulses to jump off her balcony, move from her lonely apartment on the twenty-sixth floor to a cheerful and socially active residence club on the ground floor.

Conclusion

We have found the experience of group therapy with suicidal persons to be challenging and rewarding. Initially, there were the necessary steps of self-reflection (what do we have to offer?), careful planning (what are the goals and objectives of such a group? What population do we draw from?), and convincing others of the usefulness of the endeavor (how do we actually set up such a group?).

 Whereas a group may be efficiently led by one therapist, it is recommended that a cotherapist be utilized. Didactic techniques were found to be a useful supplement, both as a tool for the therapist and also as a source of insight for the patient. An open-ended policy allowed for a continued growth experience, with a continuous influx of new members, and necessitated dealing repeatedly with such issues as increasing size, competition for attention, sibling rivalry and separation. It provided an experience that proved to be a source of self-esteem for more experienced members and a ready source of identification for new members. The therapeutic value of a policy of encouraging unbridled expression of rage or other heavily charged affect was called into question.

The group offers depressed and suicidal persons first and foremost unconditional acceptance, a focus on understanding depression, a framework in which they feel worthy of love and gradually learn to risk expressing anger and other negative feelings without the accompanying loss of self-esteem. The group offers concern, interaction, and interpersonal relationships that carry over into the members' lives outside the group. We have mentioned the use of the telephone and that we have periodic social events and parties.

We have been impressed with the group's inherent growth. In such a group the depressed and suicidal person feels that he is not alone or unique and has little need to maintain secrecy or isolation. He becomes encouraged...
to explore his alienating and self-destructive behavior. It has been inspiring to witness individuals who valued only death, change and value life.

Bibliography