Observations on Long-Term Group Therapy
with Suicidal and Depressed Persons

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ABSTRACT. A long-term, open-ended group for depressed and suicidal individuals who had made suicide attempts is described. Two hundred persons participated in the sample groups over a 46-month period, with only 10 suicide attempts and 1 suicide occurring in this high risk group during the period of the study. Our observations corroborated some findings and differed with others reported of experiences with groups of individuals who have manifested suicidal behavior. The paper includes recommendations for starting groups of suicidal persons and emphasizes that this method of therapy appears to be an effective mode of suicide prevention.

The work of suicide prevention is proceeding along three basic lines: first, research to isolate and evaluate the variables that serve as precipitating or predisposing factors to suicide; second, establishment of community-oriented suicide prevention and crisis centers; and third, implementation of effective therapeutic techniques, once the suicidal or depressed person has been identified.

There is much evidence that therapeutic efforts are not keeping pace with the rapid advances in establishing centers and developing assessment tests. A common source of dismay among mental health and crisis workers is the frequency with which a person identified as a high suicidal risk and referred for help commits suicide, often after several attempts of increasing lethality. A suicide attempt may be viewed as an attempt to modify or escape from unbearable circumstances or stress. However, it also demonstrates the "ineffectiveness" of whatever therapeutic efforts were instituted to develop the

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emotional resources required to cope with the pain of living. It is immediately apparent that work being done to prevent suicide is of limited usefulness if subsequent management is unable to guard against subsequent suicidal behavior.

Mintz (1961) rightly pointed out that “whatever may be one’s personal conviction regarding the theoretical formulations and emphasis of various psycho-therapeutic ‘schools,’ one fact is incontestable: all forms of psychotherapy are ineffective with a dead patient.” The primary concern of any therapeutic venture with suicidal and depressed persons is the preservation of life. When dealing with life-threatening disorders, openness to new ideas is essential for success with depressed and discouraged people.

The question might be asked, “Why group therapy?” Slavson (1947) suggested that the phenomenon of grouping has always been with us. “The collective instinct is a biological device for survival, and it is a compelling need in living tissue organisms, and to some extent, also in inanimate matter.” It appears that among living organisms, life does not really exist without a group. This was aptly described by Kaiser (1965) as the quest for “connectedness” or a delusion of “fusion.” As Motto and Stein (unpublished paper) suggested, the need to feel “accepted” is part of a “unifying relationship which is an especially compelling need in depressive and suicidal states.”

For several reasons, we have found group therapy to be a sensible treatment modality for depressed and suicidal persons: (a) the problems of alienation and loneliness and the need to feel accepted and be part of a unifying 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 possibly helped than with other methods.

There are several previous reports of group therapy with suicidal individuals (Alfaro, 1970; Farberow, 1968, 1972; Frederick & Farberow, 1970; Indin, 1966; Levine & Schild, 1969; Reiss, 1968). To our surprise, 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 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 sure of how to begin such a group, of the necessary first steps. It is our hope that recounting our experience in starting a group 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: (a) what did we have to offer? (b) what would be the goals and objectives of our group? (c) what population would we draw from? and (d) 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 to 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 would serve 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 colleagues.

The groups we set up and are still working with are open-ended and made up entirely of persons either admitted to a psychiatric ward or referred to us because of suicidal attempts and severe depressive states. Meetings for three separate groups are held once a week for 2½ hours per meeting. Two groups (total number, 165) meet at the San Francisco General Hospital, one at night and the other in the afternoon. These two groups are affiliated with the
Mission District Community Mental Health Center and draw members from a low socioeconomic area of the city. Another group (total number of members over 20 months was 35) meets in the Sunset District Community Mental Health Center and draws members primarily from a middle-class population. Over a 46-month period, 200 patients have participated including 98 males and 102 females ranging in age from 18 to 66 years.

Participation is entirely voluntary. The invitation has been little more than, "You're welcome to attend." Each group has committed itself to meet each week without exception in order to function in a crisis role. Even after group members have terminated their relationship with the group, they are reminded that the meetings will continue at the appointed time and place and they may return if a need ever arises. A significant number have utilized the group in this manner. There is no contract between therapists and members regarding attendance, but even without attendance requirements, 70 persons have participated for continuous periods of time ranging from 6 to 30 months.

One suicide and 10 suicide attempts are known to have occurred in this very high risk population since the groups began to function. The suicide attempts were manifestations of severe conflicts centering around a patient's gradual relinquishing of dependency needs and the anxiety produced when the patient was not certain of his ability to cope with the new sense of independence. The actual suicide occurred when the wife of the patient refused to return to him even after significant improvement during the course of treatment. In this instance the patient had participated weekly for six months.

Observations and Discussion

For the first 9 months of the 46-month period there was only one group and one therapist. However, because those who work with a group of this kind are exposed to the intimate experiences associated with death and the threat of death and feel its accompanying anxiety, the work is emotionally taxing and a cotherapist is a real 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. It has been verified for these groups that the emotional support, added insight, and dilution of transference are greatly facilitated by the presence of a cotherapist. This corroborates the conclusion of Farberow (1968, 1972) and of Motto and Stein (unpublished paper) that cotherapists facilitate group work with depressed or suicidal patients.

Group techniques, as mentioned earlier, are presently moving away from standardization toward needed flexibility. This is also true of group work with depressed and suicidal persons. Our experience has differed in several ways from that reported by other investigators. For example, it has been reported elsewhere (Alfaro, 1970; Farberow, 1968; Indin, 1966) that careful selection of patients is of primary importance in preventing reinforcement of suicidal tendencies in the group, but we found no need to artificially construct the group membership. We have also found it unnecessary to separate the groups for long-term and short-term therapy, as was suggested by Alfaro (1970) and Farberow (1972). We concur with Farberow (1968, 1972) and Levine and Schild (1969) that long-term members help new members. Farberow (1968, p. 332) has strongly recommended the presence of one person exhibiting sociopathic symptoms in order to "reach the depressives and encourage them to venture out of their defended-in-depth shells." We did not find that the presence of a sociopath made such a contribution; on the contrary, at times it proved to be extremely distracting. Indin (1966) reported that interaction should not be carried outside of the group. However, our experience parallels that of Farberow (1972) that the interaction, concern, and interpersonal relationships facilitated by participating in the group carried over in an affirming and supportive way to life outside the group situation. We have found that periodic social functions, such as group dinners and parties, especially on birthdays and around holidays, have been a vital part of our groups. We have found the telephone to be a useful tool. We share our home telephone numbers, and members call each other or the cotherapists when severely depressed or acutely suicidal. Our experience has been that this has not been abused but rather that telephone calls have been the communicative links members have used when they have been unable to handle an acute crisis alone.

Indin (1966) indicated that all actions were to be transformed into words, that acting out was inappropriate in the group. We have found that expressions of anger and physical contact have been extremely supportive, but only after the patient knows that his behavior will not be a source of rejection by the group. We differ from Farberow (1968) in not forcing or demanding certain behavior in our groups; for example, members may remain silent.
if they choose. Several observations on therapeutic processes from
the group experience might be made. While dynamic, interpretive,
and behavioristic techniques were most widely used, didactic tech-
niques were also extremely useful. Didactic material covered the
role of rage in the etiology of suicidal and depressive states, anx-
xiety threshold, defenses against anxiety, learned repression of rage,
the pain-rage dyad, and nonselective cortical-hypothalamic inhibi-
tion as sources of vegetative symptoms. It might be expected that
this information would prove to be of little value to the patient.
However, it not only gave the patient some insight into his own
problems but often facilitated his response to others. Insight, al-
though important, is only one step toward remission of symptoms
and subsequent management of the pathology itself. Didactic tech-
niques appeared to be helpful in initiating this process.

Just as insight is only one step, therapeutic catharsis, especially
regarding rage reduction, is also just a step toward remission of
symptoms. With several severely depressed patients, the expression
of highly charged material has left the patient shaken, insecure,
and unable to assimilate the encouragement and reassurance of the
group. Under ideal conditions, the freedom to express rage or other
emotion-laden feelings is a desired goal in any sort of therapeutic
venture. However, the ventilation of intense affect may do little
more than make the patient feel temporarily better. Under less
than ideal conditions, ventilation of these feelings may do harm to
the patient.

There are three elements that, if present, facilitate whatever
therapeutic benefit may be realized from the release of threatening
material:

1. The patient should have a conscious awareness of being an-
gry. One of the most prominent findings was that many of the pa-
tients not only denied being angry but also denied feeling anything.
"I don't want to feel anything." Coming into contact with threat-
ening feelings is a process that may be efficiently facilitated by an
open-ended group policy. Persons who have been in the group for
a longer period of time assume the role of "old-timers." They often
can be quite helpful in sensing and helping the newer members to
identify various painful feelings. It is common to hear an older pa-
tient say in response to a new member, "I don't know about you,
but I think that would really bother me." This is not only helpful
to the newer members but a source of esteem for the "old-timers." They
feel helpful and needed and often they are at least as percep-
tive and at times more helpful than the therapist.

2. It is helpful for the patient to be acquainted with the threat
of anger and the defensive mechanism that prevents his awareness
of anger. The most common threat is that of rejection by others
and a resulting rejection of self by self. Also common is the threat
of loss of love or esteem if negative or angry feelings are expressed.
When these fears have been an operational reality for many years,
it is unrealistic to expect the repressing-suppressing mechanism to
be significantly altered by expression of the repressed material. It
appears that it is not so much the capacity to express emotion-
laden feelings that has been hampered as the freedom to express
them.

3. For the depressed and suicidal patient, the third element is
most important. It is the assurance that the patient feels no threat
of rejection or loss of esteem in the group atmosphere. This re-
quirement is met by maintaining an honest, consistent, caring atmos-
phere that attempts to convey a feeling of acceptance and esteem.
The atmosphere of acceptance is made possible when an individual
in the group responds to another individual in the group in such
messages as: (a) "You may do and say things I don't like but that
does not mean I don't like you." (b) "You have a right to feel as
you do." (c) "There is much more to you than what you do or
say." (d) "I will be as honest with you as I can be. That means
telling you my negative feelings in the hope that you will allow
yourself to believe my positive feelings about you when I give
them to you." Under these conditions, when buried material does
come out it may be dealt with in such a way that the patient is
assured that his feelings are respected and he is accepted.

These three elements provide a therapeutic framework through
which the patient may come to feel that he is worthy of some life-
saving esteem. Constructive change beginning here may extend
gradually into the larger world.

It has been interesting to watch the creation of what we refer
to as a "core group." These are persons who have become long-term
members (6 to 30 months), and several function as "assistant ther-
apists." Their voluntary commitment to the group becomes an act
of taking personal responsibility for themselves and taking an active
part in their own therapy. As a result they are more open to recog-
nizing their own contribution to their depressive state (i.e., over-
reaction to others, assuming that everything that is unpleasant
around them is their fault, and fear of expressing their feelings be-
cause of a fear of rejection). As this growth takes place the "core"
members tend to take an extremely active role in working with
others, especially newer members in the group, and this becomes another source of self-esteem. In this manner “cliqueism” is avoided, as reaching out to others is seen as a positive and desired manner of responding. In this model the patient assumes responsibility for his own discharge. Currently we have 18 “core members” in our three groups, which means that 52 “core members” have discharged themselves and as of the last follow-up all except the one suicide are doing well. Several of these have returned to the group for brief periods during times of severe stress but, by and large, this has been a stable population.

Some concern has been expressed regarding the effect on individual members of a group composed entirely of suicidal individuals. It has been our experience that with rare exceptions the issue of suicide loses most of its impact in such a group. In this setting, there is nothing remarkable or unique about a suicide attempt except as an area of common experience. The primary issues of concern are essentially the same as with other types of groups (i.e., loneliness, problems relating to interpersonal relationships, and fears of rejection, etc.).

Group therapy with depressed and suicidal persons involves people who have experienced frustration and interpersonal depletion, whose greatest fear is rejection and subsequent isolation. Depressed persons are often characterized as being immature, infantile, demanding, and loaded with dependency needs. These preconceptions often disrupt and destroy any sort of relationship between therapist and patient. There is also a good chance that it will limit the effectiveness of any future therapy. All too often, dependency needs on the part of the patient have been met by increasing anxiety on the part of the therapist. For a patient whose life appears to him to be a sequence of rejections, this “moving away” by the therapist may be seen as the last straw. There is no doubt that some patients are infantile, immature, and demanding. Two weeks of hospitalization and intensive therapy are not going to affect this behavior pattern appreciably, especially if the therapy itself is seen by the patient as an attempt to get him out of the hospital or treatment setting. The therapist’s expectations are unrealistic if he expects the patient to cope adequately with a threatening environment with inadequate resources. The patient has had a lifetime to develop means of adapting and coping with pain. The therapist cannot expect to remodel this structure without the confidence and esteem of the patient. The time will slowly come when the patient feels that the therapist and the group believe in him, and he will begin to believe in himself. Making premature demands or posing unrealistic challenges sets the patient up to fail. This failure fits the picture the patient has of himself.

Another common fear expressed by a depressed suicidal patient is that he is becoming a burden. A threatening choice-point arises when a patient so desperately needs to be esteemed and needed, yet is afraid of rejection or becoming a burden. “What do I really have to offer? I’m no good to anyone, not even myself.” This is merely the first cry for help. It should not be heard as a manipulation or an effort on the part of the patient to force the therapist to meet his dependency needs. Any manipulation is designed to acquire for the individual something that he is certain will not be given freely. This kind of manipulation is not necessary in a group setting where the patient’s needs are seen as legitimate and realistic.

The need to be loved and needed is a universal need. In most cases, the perception of being unloved and unwanted is faulty. This should be recognized and dealt with accordingly. However, there are some instances in which this perception is realistic. In these cases it is essential that the patient’s sense of worthiness of esteem be reinforced.

We have found it to be a unique and profound experience to work with suicidal persons. These patients have all 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. 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 an acutely suicidal member move from a lonely apartment on the 20th floor to a cheerful residence club on the ground floor!

Summary and Conclusions

Recurrent suicidal activity not only indicates an attempt to escape from or modify painful circumstances but also illustrates the relative ineffectiveness of whatever therapeutic interventions were instituted. Whereas dogmatic adherence to any particular school of therapeutic thought is undesirable, effective and efficient treatment modalities are needed.

When considering the depressed patient’s need to feel accepted and part of a unifying and supporting relationship, the group treatment mode seems indicated.
We have found the experience of group therapy with suicidal persons to be a difficult but rewarding one. Initially there were the necessary steps of (a) self-reflection (What do we have to offer?), (b) careful planning (What are the goals and objectives of such a group? What population do we draw from?), and (c) 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, not only as a tool for the therapist but also as a source of insight for the patient. An open-ended policy provided a cadre of experience that proved to be a source of self-esteem for more experienced members and 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. It was found that creating an atmosphere of honesty tempered with mutual acceptance and unconditional esteem encouraged expression of feelings without guilt or fear. During these periods the patient was reassured that the revelation of negative feelings did not result in loss of esteem.

The group offers the depressed and suicidal person first and foremost unconditional acceptance, a focus on understanding depression, a framework in which he feels worthy of love and gradually learns to risk expressing anger and other negative feelings without an 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 two or three times a year, especially around the holidays. We have been impressed with the group's inherent growth. Here, the depressed and suicidal person feels that he is not alone or unique and has no need to maintain secrecy or isolation.

References
