Medication-support Groups: are they "Group Therapy"?

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Abstract

Medications and group therapy are important parts of most treatment plans but are rarely provided simultaneously. This article reviews combining these powerful modalities in medication-support groups (MSGs). Co-therapy is often necessary to lead MSGs because they require skill in group therapy and medication prescribing. Successful MSGs further group-based clinic culture. Introduction.

Key-words: treatment mental illness, support-groups, group' format, group's process, group's psychoterapy

Group therapy in the United States is undergoing another wave of increased popularity but is still underutilized. (1). In general, our pharmacological and psychological approaches to treating mental illness are increasing in number and sophistication. Unfortunately the rich potential of group therapy is often undercut by two common misperceptions: 1) efficiency is the only reason to use group therapy and only time-limited groups are efficient and 2) group therapy should always be weekly and based on depth psychologies. Members both inside and outside the group therapy community use narrow views of group therapy to justify limited group offerings in their clinics.

A wide variety of group therapies should flourish in mental health care systems. Time-limited psychodynamic groups, cognitive-behavioral groups, psycho-educational groups, and medication-support groups are a few key formats that lend themselves to resource-sensitive environments, and they all have their place in a clinic providing comprehensive services. Articles and even books are written on the first three modalities but there is little recently available on the last. This article concentrates on medication-support groups for two reasons: 1) they are under-addressed in the group therapy literature and 2) the medication management component offers an easy handle for group-naive administrators. Medication-support groups can provide better care for patients, opportunities to practice group therapy to interested clinicians, and a way to get a foot in the door for those wishing to pave the way for a more comprehensive group program!

That medication-support groups combine two potent treatments is intuitively sound (2) and can be further supported by consulting the literature on medication and on group therapy as well as the few studies combining the two. However, in this day and age of "double blind placebo controlled studies," many people ignore MSGs because they lack an extensive empiric basis. Ideally, there would be studies clarifying how to

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combine group therapy and medication. Fortunately, there are an increasing number of studies covering a variety of illnesses and populations including primary dysthymia (3), depressed medically ill (4), social phobia (5), bipolar disorder (6), obsessive-compulsive disorder (7), schizophrenia (8), personality disorders (9), and opiate abuse (10) but there is no landmark study or study looking at MSGs with heterogeneous membership. Effectiveness is largely "a given" just as it is in many medical interventions that have good face value. Even if a manualized treatment were proven effective (that is works better than placebo under highly controlled experimental conditions), its efficacy would still remain open to question. Would it work in the less controlled real world of a clinic? Medication-support groups work where they are used but are challenging to implement. This article will attempt to address some of those challenges.

In addition to dealing with the common patient and clinician reluctance to group therapy, one must overcome several additional barriers to set up MSGs. Patient's resistances to joining a MSG focus on the medication and its meaning to them and others. There is also a lack of qualified and interested practitioners, and MSGs have a biased historical legacy out of which comes inadequate models to overcome administrative barriers inherent in running multiple groups.

Most people are reluctant to reveal weakness and vulnerability in a new group. Taking psychiatric medication is still highly stigmatized. (11) Some patients struggle to remember to take their medication. The issues of stigma and ambivalence underlie many of the difficulties starting MSGs. As is the case with most resistances to group, the reluctance to divulge a secret and the complicated meanings of taking a pill daily can be reframed to clarify the importance of the group. Most if not all members take medication and can reliably affirm medication as part of a treatment plan. Furthermore, members, more than the psychiatrists, can understand the unique vicissitudes of struggling with a daily choice so imbued with meaning and so likely to generate ambivalence.

In much of the world, psychiatrists are responsible for prescribing medication in mental health clinics, so an MSG must include a psychiatrist. Unfortunately, few psychiatrists are sufficiently familiar with group therapy to feel comfortable taking the lead in setting up medication-support groups. However, staffing difficulties are not limited to finding adequately trained psychiatrists.

Accomplished group therapists often dislike the limitations of leading an MSG. Medication-support groups do not provide a therapeutic container sufficient for all of the therapeutic factors. On the other hand, failure to manage the powerful currents that underlie the potency of those same factors requires group therapy expertise. Either the psychiatrist must be sufficiently trained to manage them or more commonly a co-therapist must manage that part. In order to maximize the potential of the MSG, some treatment goals that are amenable to weekly psychodynamic group therapy must be diverted to other treatment settings where the patient's additional needs will be met. Ideally, each system of care would have groups that met more frequently and included medication management as well as providing an opportunity

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to mobilize all of the therapeutic factors. Larger systems of care are more likely to achieve this.

A literature review reveals that the historical legacy of medication groups consists primarily of efforts aimed at treating schizophrenia in public health settings. This has two important consequences: 1) most clinicians view medication groups as solely the province of the severely mentally ill and 2) the models for medication groups and how they fit into clinics was largely determined by their being for one segment of the mentally ill population. Simply stated, a clinic for psychotic patients is different than one for anxious and depressed patients. Clinics for the latter population have not developed models that allow integration of medication support groups.

Literature Review

In 1978 (12), Dr. James Sabin articulated a rationale for managing patient's medication in groups. He reviewed the established efficacy of the major medication classes and cited studies supporting the contention that group medication management was probably better but was definitely at least as good as individual medication management in severe mental illnesses. He also reviewed the available literature on psychotherapy and found support for medication groups in the work of Frank and Hogarty. Frank noted that relationship, setting, rationale, and task are four key features of successful psychotherapies. Hogarty et al emphasized the role of continuity in care and the importance of therapist morale. Despite such a thoughtful and comprehensive article, medication-support groups remained relatively uncommon except in community mental health centers treating severely ill patients, such as schizophrenia.

In the early 90's, there were some excellent articles on group therapy and medication, but they tended to focus either on the impact that medication has on concurrent treatment in psychodynamic group therapy or on medication groups for the severely and persistently mentally ill. In the first category: Paul Rodenhauser's 1989 article (13) reviewed the difference between pharmacotherapy's impact on patients in individual vs. group therapy. In the same issue of IJGP, Zaslav and Kalb turned the issue of "medications in psychodynamic groups" into an opportunity to understand the patients by viewing medication as a metaphor (14). Subsequent to those efforts, Stone and Market teamed up with Rodenhauser in 1991 (15) to survey the experiences and views of selected group therapists on medication and group therapy. Two-thirds of the surveyed therapists said their group included members who were taking medication and "did not view inclusion of drugs as a detriment to the treatment process." While not declared helpful, at least medications were not viewed as destructive. Interestingly, there was little difference between disciplines as to whether medicated patients should be included but social workers and psychologists did disagree with psychiatrists regarding whether "medicated patients needed to be in groups led by psychiatrists."

Salvendy and Joffe take a more upbeat approach (16) and suggest that we "consider depression as a relatively frequent cause of impasse in the course of group therapy." They go on to "recommend the combined use of antidepressant medication along with group psychotherapy when such depression is confirmed independently outside the group." Medications can be helpful to group therapy but, for a complete assessment, the need for medication must be assessed outside the group.

Kahn and Kahn moved forward the effort to provide better and more specific group therapy for individuals suffering from schizophrenia (17), an illness where medication is essentially always part of the illness' management. Citing research findings, they note that the type of group format chosen is "often based on pragmatism or inclination, rather than theory or experiment." They break down the groups for schizophrenics into four types: 1) convenience, 2) topical, 3) those based on phase, and 4) eclectic. MSGs are similar to "topical groups" and "eclectic groups." Kahn and Kahn note that topical groups provide "an avenue for desensitizing reluctant patients to group experiences," and can have a role in training group clinicians. "Once content is defined and facilitative methods are chosen, it is easy to train staff members to run topical groups." They do not address medication as a special topic and strive for more homogeneous groups. Their schema for assigning patients to groups is based on such parameters as ability to focus, abstract, and tolerate higher levels of affective tone. Although the mechanism for introducing patients to group therapy is not addressed as part of their article, more than likely patients were transferred from one clinician to another in order to place them in the specialized group that best fits their needs.

Also during the early 1990's, McIntosh, Stone, and Grace described what they term "flexible boundaried groups."(18) The model was "developed to manage the problem of irregular group attendance by chronic mentally ill patients." The found it useful to explicitly give the patients more say in how often they attended the group. In their description of the group, they note that some members are "regular, core attendees" and others are "peripheral members." Despite the potential disruption of the latter, the groups were noted to become cohesive and well regarded by participating members.

De Bosset also wrote about setting up groups for the chronically ill patients. The "Toronto Model" (19) involved a 60 minute group as the 1st hour of a 3 hour clinic. The group was "supportive and reality-oriented with emphasis on interpersonal learning." During the 2nd hour, psychiatry residents provided medication management in individual sessions while patients were allowed to mingle. The last hour was a staff meeting reviewing the sessions with the patients. The therapists included a resident and non-physician staff person, and their role was "that of catalyst, reality tester, and educator."

This brief literature review reveals that most models for medication groups focus on schizophrenia although that may be changing. Flexible-boundaried groups offer a framework useful in setting up MSGs with heterogeneous membership that emphasize the benefits of Kahn and Kahn's eclectic group.

The Adult Psychiatric Support Services Clinic: History, Setting, and Mission

The Adult Psychiatric Support Services clinic is 3 years old. It is part of Sacramento County Mental Health and is staffed by University of California Davis faculty, trainees, and county administrative staff. The county is in Central California and includes the state capital. The population is approaching ½ million and the area is surrounded by farmland and the Sierra Nevada mountains.

The clinic serves a higher functioning and less chronic portion of the county's mentally ill clientele. The two primary payers are Managed Medicaid Plans, federal government grants to local municipalities for capitated healthcare, and CalWorks, a welfare-to-work program.

Managed Medicaid covers individuals who receive government assistance for non-psychiatric reasons. Medicaid recipients are referred to our clinic if they have a non-core mental illness and/or Global Assessment of Function Scale Scores (GAFs) over 60. Examples of non-core target diagnoses are panic disorder and major depression, single episode.

CalWorks patients are in a comprehensive program that includes job training and other services in addition to mental health services. Master's level clinicians refer patients to APSS for medication evaluation and management. Other clinics provide counseling services such as psycho-educational groups, time-limited support groups and time-limited individual therapy. Each social worker carries a caseloads of unemployed people trying to transition from welfare to work.

The MSG Model

The MSG model took 6 years to evolve to its current state and is efficient, practical, and provides good care. The groups appear to be at least equivalently efficacious as individual medication management. In other words, patients who are managed in MSGs appear to fair as well as those seen individually. A formal study is being planned using a quasi-experimental design but has been delayed by difficulties developing a reliable data base and data entry mechanism. A study of effectiveness is impractical in this clinic setting because we do not have research staff to set up a double blind placebo controlled project.

MSGs are led by at least one psychiatrist and often a co-therapist (social worker or resident). There are often medical student observers. The clinic has 4 part-time attending psychiatrists (2.4 FTE), a part-time social worker, a part-time psychologist (0.6 FTE), a full-time mental health counselor, and 2 full-time residents. The two most clinically active attending psychiatrists and both residents run at least 2 groups per week, one in the morning and another in the afternoon. In total there are 7 MSGs per week (2 with one attending, 4 with an attending and resident, and one with an attending and a social worker). Each MSG is scheduled to be 75 minutes long plus 15 minutes for completing notes. If there are trainees involved, 30 minutes are available

for supervision. Group membership changes each week. Frequency is based on patient acuity so that attendance increases in order to manage recent medication changes and/or to provide additional support. The leader and patient schedule the next visit during the group. Scheduled intervals between groups ranges from a few days to every 3 months. Patients may call and reschedule themselves either earlier because of a new concern or later if they can not make the scheduled appointment. Administrative staff attempt to keep patients going to the same provider's groups in order to enhance continuity. With two meetings a week, early appointments and rescheduling is easily accomplished. Patients are strongly discouraged from "walking in."

Group Format
At the beginning of the group, the therapist arranges the patients' charts, his/her prescription pad, the schedule, and an MSG binder within easy reach. The MSG binder contains lab slips, progress sheets, medication consents, medication summary sheets, treatment authorization requests, formularies, and referral forms. One clinician sets the stage and emphasizes universality, giving and receiving advice, learning from the group leaders, and from each other about their medications and managing their illnesses. The meetings are structured and rely on a spoke-wheel approach for check-in with liberal encouragement of member-member interaction within that framework. Leaders actively solicit comments and participation by members for various topics brought up by check-ins. However, these discussions are short and are necessarily concluded in order to continue the group. The group focuses on issues relevant to medication management, support and often involves education. At the beginning of the group, members are provided "next appointment cards" which also have written on them the items to focus on during their check-in:
1) what medications and doses the patient takes
2) how the medications help (target symptoms)
3) what problems they cause (side effects) and
4) any big events (stressors).
The progress notes are written on a template and often completed during the group as are prescriptions, signing consents, and ordering labs. Patients select the order of check in and the group ends when all the patients have been evaluated, labs ordered, referrals made, and prescriptions written.

Group's Process
Medication-support groups are semi-structured in order to address their dual purpose. The whole group is a series of extended check-ins, each of which involves answering a prescribed set of 4 questions. Although members are taking turns, they are encouraged to interact with each other throughout the group. The 1st three questions of the check-in cover basic medication management, and the 4th focuses on coping and support. Any of the questions can be the start of a brief, focused group discussion. Depending on the number of members and the anticipated needs of the

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remaining patients, the therapists may encourage further group discussion or ask a series of questions themselves. In the latter case, members still have the opportunity for vicarious learning as the leaders expedite the clinical evaluation in order to manage the group's limited time. Fortunately, the former is more common. Members are encouraged to interact with each other in focused discussions that last 2-10 minutes. Although any question can be the stimulus for these discussions, most often the fourth question on "life events" is the starting place. Rather than focusing solely on medication and medical evaluation, common discussion topics include coping with co-morbid medical problems, problem partners, difficulty finding or keeping a job, taking care of ill children or grandchildren, and negotiating bureaucracies. The length of a patient's check-in depends on her needs and on whether the discussion resonates with other members. Generally, one of the leaders concludes a member's turn by enquiring when she wants to have her next appointment. As much as possible this is done at the natural breaks in the group's ebb and flow. As in any focused group, occasionally the leaders must contain a garrulous or grossly inappropriate patient and sometimes must redirect them to other clinic resources.

Both leaders and patients work together to carry out the group's primary activities. Checking for dangerous side effects and medication interactions, discussing medication changes and deciding on new courses of treatment are the topics addressed primarily by the psychiatrist(s). Either leader may ask questions and encourage discussion that will be inherently therapeutic as well as clarify each patient's clinical status. Frequently, members with the same illness will also ask each other useful questions. In a similar vein, both the leaders and the members offer support and suggestions. The leaders often elicit comments of support from other members by asking questions such as "Has anyone else struggled with [problem "X"]?" and "What sorts of solutions did other people use to deal with [problem "Y"]?" Members provide a significant number of the supportive comments, advice and suggestions. Similar to other groups, members have more credibility than the therapists in many circumstances. A healthy therapist telling a hypomanic patient to take their Depakote and decrease their stimulation level is different from another patient with bipolar disorder who can empathize with the desire to remain hypomanic and yet she can provide firm support for therapeutic medication changes. Similarly, one member's first hand experience with a medication can ease a peer's mind regarding a new regimen's tolerability. MSGs offer psychiatrists providing medication management an opportunity for a "credibility boost" when they establish a healthy group culture regarding appropriate use of medication.

MSGs mobilize many of Yalom's therapeutic factors including instillation of hope, universality, imparting of information, altruism, and catharsis. Because the group is heterogeneous in terms of length of treatment, senior members who are doing well can model for new patients that medication can be an important part of a successful treatment plan. Many members comment on being relieved to find out that they are not the only ones facing a mental illness and other shared difficulties. Between the book-learning of the leaders and the practical experience of the patients, each MSG is

a diverse and comprehensive repository of knowledge. Patients often enjoy helping each other and can see how far they themselves have come. While not a prominent therapeutic factor, many patients seem to find relief in sharing and expressing their pain. While MSGs have limits, they offer an opportunity to invoke a potent set of therapeutic factors.

Results
Ease of Set-Up
The University of California at Davis model took several years to evolve. In 1996, four medication groups were set up in the university clinic and modeled after the monthly "lithium group." After 18 months, the groups were made more frequent in order to avoid crowding. A referral system allowed patients to be transferred from the initial evaluation to the depressive disorders group, bipolar disorders group, or psychotic disorders group. In 1998, the author (PC) moved to APSS a new and developing clinic. The program started with 2 equivalent weekly MSGs, one in the morning and another in the afternoon. As the groups grew in size and as administrative resources were cut, many modifications and adjustments were necessary. As part of an effort to improve treatment for dually diagnosed clients, an MSG specifically for that population was started. After less than 2 years, the average attendance at the MSGs grew too high and the number of MSGs was increased from 3 per week to 7 per week. This led to the desired result of fewer members per group and increased the morale of the group leaders and members alike. The current model works. The doubling of groups did not double the administrative activity.

Efficiency
The groups are remarkably efficient. There are usually 4-7 members. Two group leaders running a group of 6-7 members takes the full 75 minutes. The average time per patient is 10-18 minutes or each patient takes 20-35 clinician-minutes (time per patient multiplied by 2 therapists). Although 20-35 minutes is comparable to what is scheduled for individual medication management visits, many patients fail to keep their individual appointments which means that the average time per patient is longer than the allotted 30 minutes. MSGs are a more efficient use of clinician time.

As the flexibility of the group format is more forgiving than individual visits in terms of absorbing no-shows, MSGs are also more flexible in accommodating extra visits. Adding a 7th person to a 6 member group makes little difference to all concerned. Scheduling an additional individual follow-up is often very difficult because most individual slots are filled weeks ahead. It is easy to appreciate how efficient the MSGs are.

Discussion
Establishing medication-support groups

Any clinic starting MSGs can almost immediately benefit from the increased flexibility and efficiency, but there are start-up costs. The primary barriers to starting involve 1) group leadership with dual expertise, 2) extra administrative back up & 3) the clinic's cultural shift, either in terms of individual to group or, less commonly, non-medication group to medication-support group.

MSGs require leaders with group therapy expertise and pharmacological sophistication. If the MSG can have only one leader, then they must be able to carry out prescribing responsibilities. Unfortunately, many psychiatry residency programs provide only cursory exposure to group therapy, and opportunities to learn how to run MSGs are even less common. As a result, co-therapy is usually the best choice. Cotherapy allows leaders with different skill sets to collaborate. The usual challenges and opportunities of co-therapy are available.

Going from individually-focused to group-focused treatment is a major cultural shift. MSGs and psycho-educational groups can be good starting places in clinics that emphasize pharmacological interventions and brief treatment models. When successfully started, MSGs pave the way for other new groups. The process becomes a positive feedback loop for patients, clinical and administrative staff. Patients are more amenable to other group referrals once they have a positive group experience. Staff become more capable of articulating how the MSG will be an advantage for the patient.

Group infrastructure

The MSG's semi-structured approach evolved from a less structured one. Tracing the evolution of the changes is worthwhile as it illustrates some of the differences between homogenous and heterogeneous group membership. The illness-focused or medication-focused group, perhaps epitomized by the "lithium group," turns out to be very different from those with more a diverse clientele. Our groups have members with many different conditions including mood, anxiety, substance abuse, and personality disorders. They are treated with a variety of medications and psychological treatments.

Originally, the group began with a ten-minute go-round followed by a group discussion. All members briefly reported their current status and had an opportunity to identify a troublesome topic or concern that they would like to discuss with the group. This approach did not work for several reasons. Patients had difficulty checking in concisely, identifying topics for discussion, and sticking to a topic. Furthermore, some of the leaders were trainees who were new to outpatient psychiatry and found the lack of structure too anxiety provoking.

Managing anxiety is the most challenging barrier to running successful MSGs. Irregular attendance albeit scheduled makes group composition unpredictable and leads to varying degrees of group cohesiveness. Group cohesiveness is a potent force. It stabilizes the group and assists members in proceeding therapeutically by helping them tolerate anxiety better during the group. However, group cohesiveness is not the

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only way to manage anxiety and moving through the period of anxiety inherent in some stages of group development is not necessary to achieve the group's most important therapeutic goals. Group structure helps manage anxiety, and while externally imposed structure results in an attenuated group process, the "lost opportunities" are compensated for by the patient's ability to focus and benefit from meeting the group's objectives. Members benefit from addressing the pharmacological management of their illness and revealing themselves sufficiently to the group to attain the benefits of the therapeutic factors that are available.

Leadership

In the group, there are two important roles: prescribing therapist and group process therapist. If there are two leaders, each one usually ends up taking one role or the other. Often they will alternate or take turns depending on who knows the patient better. When one is working on the details of the patient's medication, the other can ask additional questions of the patient and/or nurture a healthy group process.

As always with co-therapy, the relationship is subject to many forces, and the leaders must work to keep communication clear. This can be particularly challenging when patients need additional interventions either pharmacological, psychological or both. Once again hidden in this challenge is a golden opportunity. Which do I address first? How long should I spend on each? These competing needs force an important core issue out into the open: how does one integrate a treatment plan. Knowing when to increase the antidepressant and when to interpret resistance to starting new healthy behaviors is difficult. Members watching such a discussion can learn a great deal about how to refine their own approach to treatment. MSGs are an opportunity for vicarious learning around multiple issues, simple and complex.

Difficult patients in MSGs

The pharmacologically complicated patient is a challenge no matter where their care is provided. With two therapists, management is fairly straightforward. One therapist focuses on solving the medication issue and the other focuses on the impact of struggling with such a problem. Often the rest of the group is active, supportive and helpful. If there is only one therapist, a similar tactic is pursued but requires multi-tasking. Sometimes, the natural leadership ability of a member will surface, providing the leader with relief and the member an opportunity for altruism. Occasionally, a patient may require an hour-long individual visit in order to completely review his/her case.

The overly disclosing patient is a problem in any group at the beginning. In the MSGs, the therapeutic container is not designed to withstand such challenges . Intervening quickly to protect the patient is often necessary. Sometimes the disclosure is appropriate for a weekly therapy group but risky in the MSGs because of the lack of regular group membership and attendance. In such instances, if disclosure is an attempt to get help albeit in the wrong time and place, then the therapist must support the help-seeking behavior but divert the current ill-conceived

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attempt. One must clarify that this particular group is not the right setting for addressing such an important sensitive issue but that seeking help around it is essential. Appropriate referrals should be available.

Manic and/or suicidal patients require extra therapist attention and may at times need to be removed from the group. When there are two therapists, the approach is similar to the pharmacologically challenging patient. One manages the problem, the other works with the group. Clinicians leading MSGs alone may need to have an understanding with the rest of the clinic that they may need extra back up in such circumstances.

The garrulous patient and the severely personality disordered patient are both set ups for being scapegoated. Unfettered, they may also chase away other members. Unlike in weekly therapy groups, where group development advances when the scapegoat dynamic surfaces and is managed therapeutically, in the MSGs such work is not possible. Garrulous and severely personality disordered patients must be contained quickly by the therapist(s). In stark contrast to the difficult pharmacological, the suicidal or manic patient, leaders should discourage examination in the group of the problematic events brought on by the garrulous or severely personality disordered patients. MSGs do not lend themselves to here-and-now work. Patients with severe character pathology can still get medication in the MSG but must get the other components of their treatment elsewhere.

The withdrawn patient in an MSG is not unlike a withdrawn patient in any group. Often they are participating vicariously. However, the leaders need to hear from everyone and should ask direct questions and draw out reluctant patients as if it were a new group in its early stage. Generating support among other patients for an anxious member is also often helpful. In general, senior members can provide the support and advice of someone who has "walked in your shoes."

Conclusion

Medication-support groups (MSGs) are a viable alternative to individual medication management and to split treatments involving medication management and supportive therapy. They can be important to switching systems-of-care toward a group therapy-based model.

However, MSGs require a substantial commitment from clinic leadership and administration, and the MSG's leaders must have group therapy skills in addition to familiarity with medication and with other psychosocial interventions.

Bibliography

1) Cox PD, Ilfeld FE, Squire Ilfeld B, Brennan CS: Administrators and Group Therapists Collaborating in Group Program Development, *International Journal of Group Psychotherapy,* Vol. 56 No. 1, p 4-28; 2000

2) Kaplan HI, Sadock, BJ Eeds, Sussman N: Special practices in group psychotherapy, Williams and Wilkins Co. Baltimore, MD US 1993, *Comprehensive Group Psychotherapy*, 3rd Ed.

3) Ravindran, AV, Anisman H, Merali, Z et al: Treatment of Primary Dysthymia with Group Cognitive Therapy and Pharmacotherapy: Clinical Symptoms and Functional Impairments, *Amer. Journal of Psychiatry*, 1999, Oct. 156(10) 1608-17

4) Lee, MR, Cohen, L Hadley, SW, Goodwin, FK: Cognitive-behavioral Group Therapy with Medication for Depressed Gay Men with AIDS or Symptomatic of HIV Infection, *Psychiatric Services* 1999 July 50(7) 948-52

5) Heimberg, RG, Liebowitz, MR, Hope DA et al: Cognitive behavioral Group Therapy vs. Phenelzine Therapy for Social Phobia: 12-week outcome *Archives of General Psychiatry* 1998 Dec. 55(12) 1133-41

6) Huxley NA, Parikh SV, Baldessarini RJ; Effectiveness of Psychosocial Treatments in Bipolar Disorder: State of the Evidence, *Harvard Review of Psychiatry* 8(3) 126-40 Sep 2000

7) Althaus D, Saudig M, Hauke W, Roper G, Butollo W; The Efficacy of an Inpatient Group Therapy Program for Obsessive-Compulsive Disorder in *Addition to Individual Cognitive Behavioral Therapy and Medication*, Verhaltenstherapie 10(1) 16-23 March 2000

8) Huxley NA, Rendall M, Sederer L, Psychosocial Treatments in Schizophrenia: A Review of the Past 20 Years; *Journal of Nervous and Mental Disease* 188(4) 187-201 April 2000

9) Wilberg T, Griis S, Karterud S, Mehlum L, Urnes O, Vaglum P; Outpatient Group Psychotherapy: A Valuable Continuation Treatment for Patients with Borderline Personality Disorder Treated in a Day Hospital? A 3-year Follow-up Study; *Nordic Journal of Psychiatry* 52(3) 213-221 1998

10) Roth A, Hogan I, Farren C, Naltrexone Plus Group Therapy For the Treatment of Opiate-abusing Health-care Professionals; *Journal of Substance Abuse Treatment* 14(1) 19-22 Jan-Feb 1997

11) Benkert O, Graf-Morgenstern M, Hillert A, et al Public Opinion on Psychotropic Drugs: An Analysis of the Factors Influencing Acceptance or Rejection: *The Journal of Nervous and Mental Disease* 185(3), 151-158

12) Sabin, J, *Comprehensive Psychiatry* 19(1), January/February, 1978 83-95

13) Rodenhauser P, *IJGP* 39(4), October 1989 445-456

14) Zaslav M, Kalb *IJGP* 39(4), October 1989 457-74

15) Stone W, Market, Rodenhauser Pin 1991 (*IJGP* 41(4), October 1991 449-464

16) Salvendy and Joffe *IJGP* 41(4), October 1991 465-480

17) Kahn and Kahn Comm. *Mental Health Journal,* 28(6) December, 1992 539-50

18) McIntosh D, Stone WN, Grace MM, The Flexible Boundaried Group: Format, Techniques, and Patients' Perceptions, *International Journal of Group Psychotherapy*, 41(1) 1991 49-64

19) De Bosset F, Group Psychotherapy in Chronic Psychiatric Outpatients: A Toronto Model, *International Journal of Group Psychotherapy,* 41(1) 1991 65-78

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