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# "We Need Each Other!": Adapting the Tavistock Method for Large Group Therapy for Adults with Severe Mental Illness

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## Abstract

Wilfred Bion (1954) proposed a model of group theory known as a group-as-a-whole approach or the Tavistock method. This approach to group therapy emphasizes the unconscious, group-as-a-whole dynamics versus any individual member's process. As a means for individuals to deflect discussing their own idiosyncratic trauma history and allowing for a general discussion of trauma, this approach helps members feel safe to risk addressing painful issues in the present moment (Semmelhack, Ende, & Hazell, 2013). We hypothesize that this is the case because the Tavistock method creates, among other things, a deep sense of psychological safety (Hazell, 2005) There are a limited number of research studies examining the applicability, efficacy, and general impact of the Tavistock model on individuals diagnosed with a severe mental illness (Semmelhack, Ende & Hazell, 2013). Additionally, research studies examining the Tavistock model, and its application to group work, focus on small group settings instead of large group settings. This focus on small groups has perhaps resulted

from widespread assumptions regarding the tendency for large groups to cause regression and depersonalization in members.

This study will highlight on-going research conducted over a six month period of time utilizing a modified Tavistock approach (Semmelhack, Ende & Hazell, 2013) extending the application of the modified Tavistock method to large group work for adults with severe mental illness. It was hypothesized that group members would exhibit increased comfort and cohesiveness in the large group and reduced anxiety regarding engaging in a large group. It was also hypothesized that there would be improvements in other group dynamics such as a stable group size and the understanding of group norms. By this we mean that the group would be well attended by at least a core set of members and that a relatively stable set of growth-promoting norms such as listening and openness to experience would be understood and promulgated by group participants.

The authors conducted monthly large group sessions in the style of an adapted Tavistock method (Semmelhack, Ende & Hazell, 2013). Unlike the small groups described in the 2013 study, these large groups included 22-25 members. All groups consisted of members diagnosed with severe mental illness (e.g., Bipolar Spectrum Disorder, Schizophrenia Spectrum) residing in a long-term skilled nursing home facility. Qualitative and quantitative data, in the form of questionnaires, were collected and compiled after the completion of each group session. Data were collected after the first group session and subsequently for six total sessions. Results indicated increases in group comfort/cohesion (as defined as a desire to attend group sessions and willingness to share; Yalom, 2005), insight, emotional expression, enjoyment, and participation. It was also found that members preferred the large group size overall; however, this change in group size preference gradually increased based on the number of group sessions the member attended. Conclusions from this pilot study suggest the effectiveness of a novel application of the Tavistock method to large group work with a population of individuals with severe mental illness (Semmelhack, Ende & Hazell, 2013). Further research on large Tavistock style groups could focus on the use of the large group in the formation of a community setting in a long-term care institution and the dynamics of residing in a long-term facility. This study furthers research in group work, treatment approaches for individuals with severe mental illness, and treatments for individuals residing in a nursing home facility.

**Keywords**: Group Psychotherapy, Tavistock Group, Long-term Care, Severe Mental Illness

# Introduction:

The current study investigates the efficacy of a large group setting for a Tavistock method group for residents diagnosed with a Severe Mental Illness (SMI) living in a Skilled Nursing/Long Term Care (SNF/LTC) facility. We examined 15 group process variables over the course of six months. Using a questionnaire developed specifically for the study, the variables examined included: group comfort pre and post group sessions, group cohesion, comfort with expressing thoughts and feelings during sessions, consultant work, personal insight, enjoyment, comfort with group size, amount of participation, desire for the group sessions to continue, perceived consultant support, group size preference, and perceived lack of attention from consultants. We hypothesized that the modified Tavistock group approach in a large setting would produce statistically significant increases in scores on the 15 variables based on results from the questionnaire created for the study. Specifically, we hypothesized increases in scores related to group cohesion, participants' personal insight, group size preference, and desire for the large group to continue. In addition we were very curious as to the themes and group process that would emerge over the course of time. We thus took detailed process notes after each session and content analyzed them on an ongoing basis for six months to determine identify major themes. Thus, for example, after a member of the institution had died, much group time was spent mourning this individual. When state funding was likely to be eliminated, this created considerable anxiety in the group. Such themes were identified and recalled before the following meeting to alert consultants to possible issues that might still be emotionally significant.

This study is interesting and novel in several ways. First, it explores the use of modified Tavistock groups as a means of providing psychotherapy in a residential setting. Tavistock groups are typically not used for therapy but as a means for learning about group dynamics. Semmelhack, Ende, and Hazell (2013) demonstrate that this

approach is feasible for various group settings (i.e., prison settings, skilled nursing, long-term care). Secondly, Tavistock groups are not typically recommended as fitting for persons with the severe spectrum of diagnoses. This is because the Tavistock technique addresses unconscious material. Such an approach is assumed to be too stressful on individuals who, theoretically, have compromised reality testing. Thirdly, this study seeks to explore and demonstrate the potential therapeutic utility of a large group. There is very little research and literature on the use of large group psychotherapy. Certain organizations claim to provide therapeutic benefit in the form of large group experiences (Bry, 1984) but there is very little, if any, systematic research on the benefits of large group work, especially Tavistock approaches, with individuals diagnosed with SMI. In addition, these large group formats operate from the precepts of what might be broadly called "existential/humanistic" assumptions. The Tavistock approach being explored here differs in significant ways from these approaches.

Assumptions about large groups lead to conclusion that they would not be advisable for those with severe diagnoses. Kreeger (2012) argues that large groups have the effect of bringing about regression in the members. Freud (1922/1990) argues along similar lines, citing, "The Crowd", of LeBon (1895/2002) and positing that the large group induces a regressive identification with the group and with the leader, thus weakening the egos of the members. When one works in conferences in the Tavistock tradition (Colman & Geller, 1985), it is a commonly held assumption that far more regressive and "psychotic like" phenomena will be evidenced in the large group experience as this induces depersonalization, de-individuation and thus, in turn activates the litany of "primitive" defense mechanisms characteristic of the large group—projection, projective identification, splitting and denial. In addition, it is usually assumed that the member of a large group usually experiences some form of "narcissistic insult" owing to the frustrating dynamics and that this can lead to the eruption of intense hatred (de Mare, 2011). For these reasons alone, it is usually deemed inadvisable for persons who theoretically exhibit "weak egos" and fragile self-esteem to be placed in the potentially ego-weakening context of a large group.

The Tavistock group comes in a variety of forms but it shares certain characteristics. First, there is a focus on the group-as-a-whole. Consultations are usually aimed at the entire group, not at any specific individual. Second, there is a focus on the latent content of the group's process. Latent content involves the symbolic or unconscious material the group contains, while manifest content includes conscious or overt material expressed during the group. Thus, the group might be discussing dangerous neighborhoods in the city. This would be considered "manifest" content. However, a consultant might interpret this to have the "latent content" meaning of the group discussing the relative safety of the group in the here and now. While the consultations are aimed at different "layers" of the unconscious, ranging from the relatively superficial "hidden agendas" to the deeper layers that may invoke addressing the profound layers of impulse and image found in an array of theories, they usually (nearly always) look beyond the manifest content of the group. These attributes of Tavistock groups suggest that frequently they lead members to examine fantasies and possibilities that are not part of the consciously experienced current reality in the group. With patients where "ego building" and reality testing are often seen as being the order of the day such interventions that will be initially experienced as ego alien and "experience distant" might not be seen as meeting these ends.

Since Tavistock or group-as-a-whole groups are not among the most common of group styles as compared to psychosocial or skill building group styles utilized with this population, (for example Hill (1971,1977) notes that a more passive/reactive, highly structured approach is commonly employed when working with the severely mentally ill) we believe that several examples of interventions that were made by consultants might give the reader a more concrete idea of what occurred in the groups. This list is not complete but gives a beginning idea of the approach. Readers who are interested in reading further are directed to Colman and Geller (1985) Hazell (2005), Semmelhack, Hazell and Ende (2013,2015).

1) Derivatives: Consultations that come from this perspective take the manifest content of the group discussion and reframe it as a commentary on the underlying dynamics of the group-as-a-whole. For example, when several members spoke of the infrequency of visits from relatives and their sense of loneliness and isolation, the consultation, "The group is concerned about the lack of contact between members in the group." In this simple example, a conversation that is on the surface about, "there and then" events is taken to be a commentary on the, "here and now" situation.

2) Symptoms: When working with the severely mentally ill it is not unusual for a member to hear voices, get up and walk out of the room, break into song, have an "accident" or perhaps develop a psychosomatic reaction. In the group-as-a-whole approach, these events are treated as communications about the unconscious dynamics of the group. They are decoded and fed back to the group in a less metaphorical form. For example, when a member repeatedly sang the nursery rhyme, "Rockabye Baby", the interpretation that group members were feeling anxious and insecurely held in the group was offered. When a member twice spilled coffee, the interpretation that the group was overflowing with emotion was offered. When a member got up to leave, the consultation that the member was reacting to an unacknowledged rise in group anxiety was offered. These interpretations are not generated in a formulaic, lock step fashion. There has to be supporting data from other aspects of the group. In addition, the consultant waits to see if the group, through its speech and actions, affirms or negates the validity of the consultation.

3) Context: Prior to each group meeting, consultants and observers would meet for 30 minutes to discuss events that occurred in the institution and its context that might affect the community. More often than not, these events would surface explicitly in the ensuing session which then offered a means of processing these events. For example, if a member of the nursing home died, the effect of this would reverberate through the social network triggering feelings of loss, sadness and anxiety. It would also trigger memories in group members of other losses. In addition, at times the political climate at the state level would make it seem that the institution might be closed down. This would be brought up by members in the ensuing group and would be discussed. Usually these anxieties were based on the real concern that the institution might be shut down. These anxieties would also trigger anxious memories in the group for the many members that had experienced homelessness or had been foster-children.

4) Roles in the Group: At times certain individuals in the group would emerge and take up roles, often leadership roles, which seemed to serve very specific functions for the group. Quite frequently these would be consulted to, the consultant always pointing out that there was an unconscious "agreement", a collusion, between the entire group and the member that they should perform this role. For example, one member would usually start each group with a speech that was rather like a sermon. This seemed to serve several functions for the group—it gave the image of there being a kindly wise father; it uplifted the moral tone of the group and seemed to have a calming effect on one and all, even the consultants. Such a mechanism can be interpreted. As another example, another member took up the role of political representative to outside groups, politicians and interest groups when it appeared the survival of the institution was under threat. Other members took up roles of "visionary", or spokespersons for gratitude or love and kindness. Each of these roles can be seen as instances of "repository" where one member or a subgroup is asked unconsciously by the group to hold and carry an affect, idea or fantasy for the group-as-a-whole. Insofar as these dynamics involve projective identification, they are worthy topics for consultation.

5) Boundaries of the Group: The boundaries of a median group, such as the ones in this study, are more porous than the typical Tavistock group. For example, people would come and go from the group. Sometimes individuals would show up at the community meeting thinking it was the church group. Usually there were several individuals who wandered back and forth just outside of the

boundary of the group. Usually there would be an announcement over the loudspeaker. Consultants would pay attention to these events at the boundary of the group and weave them into consultations. For example, the members circling just outside the group might be thought of as containing some thoughts or feelings that the group had some difficulty containing or perhaps the member who showed up in the wrong room represented something that was seen to be missing from the group and yet desired.

6) Subjective state of the Consultant: It is common for the consultant to have reactions during such groups. These reactions might involve memories, emotions, loose associations, physical responses and defensive reactions. While many of these will reflect the individual mind of the consultant, some might indicate the underlying dynamics of the group. One way to tell if this is likely is to scan the group for supportive data. Thus, for example, at the outset of a group one consultant felt deep feelings of warmth and gratitude at being in the group, intermingled with anxiety at these tender feelings. At the same time, the group was discussing upcoming plans and hopes and anxieties for Thanksgiving. The way seemed clear for the consultant to offer the hunch that the group was pleased to reconvene, felt grateful for the riches in the group, but at the same time was anxious about possible disappointment. Such subjective responses can tip the consultant off to members' roles. For example the role of "sermonizer" mentioned before became apparent when a consultant recognized how comforted and secure he felt whenever the selected member held forth with his philosophical homilies for several minutes.

This is an incomplete list, to be sure, and it certainly falls far short of offering the reader a clear set of "how to" instructions. We hope it stimulates interest in exploring an approach which, we believe is of enormous benefit to a wide array of consumers.

Our experience, described in Semmelhack, Ende and Hazell (2013, 2015) and Hazell (2005), lead us to question these assumptions. In these texts, some 21 years of research is cited where small Tavistock groups are shown to have a beneficial impact on the mental health of the severely mentally ill participants using a variety of standard measures (e.g., BDI-II, BAI). The individuals participating in these groups were quite capable of integrating and using group-as-a-whole interpretations and would show significant benefits from such experiences.

In addition, we believe that the large group format offers significant opportunities for the experiencing of community. The "Open Dialogues" approach in Finland (Seikkula and Arnkil, 2006) demonstrates the potency of an approach that utilizes such social networks in the treatment of the severely mentally ill. We posit, along with Nancy (1991), that this need for community is equivalent to the drives posited by many other psychologists (drives such as: sex, aggression, self esteem, love and belongingness, social interest, interpersonal security etc.) and, that if this drive is frustrated many untoward symptoms emerge (Sullivan, 1968). Thus, providing for an opportunity for community experiencing, we are providing an experience that will alleviate mental suffering. In this, we follow Jones (2013), Edelson (1970), Nancy (1991), Blanchot (1988), and de Mare (2011). We are also influenced by the psychodynamically inclined anthropologists who argue cogently for the spelling out of articulations between individual personality and culture: Devereux (1980), Roheim (1971), Kardiner (1939), and Erikson (1993).

We thus decided to conduct a series of large groups following modified Tavistock procedures and to monitor and record the results with questionnaires, interviews and process notes. We believed that individuals diagnosed with SMI would gain benefits and experience the group in a therapeutic fashion.

This paper demonstrates that such a large group is feasible and beneficial for a population of severely mentally ill individuals. This paper also describes themes that emerged in the large group and managerial issues (that

were the responsibility of the consultant team) involved in conducting such a group. These themes might be of use to other practitioners conducting large groups in similar settings. At the end of our discussion, we will posit several hypotheses and formats for future research.

The groups were conducted on one Sunday afternoon a month for six months at a skilled nursing/long-term care facility (SNF/LTC) located in the suburbs of a metropolitan center in the Midwest of the USA. Attendance was entirely voluntary. The membership averaged 24 members per group (SD = 1.79), and the average composition of the groups was as follows: 8.5 males per group (SD = 1.6; 36%), 15.5 females per group (SD = 1.05; 64%), 24 members average attendance per group (SD = 1.79), and average age of the members was 60 (SD = 10.5). Members and consultants conducted the group session in a large circular arrangement. This deviation from traditional Tavistock procedure, where members sit in concentric circles or spirals, for example, was chosen for two reasons (Colman and Geller, 1985). First, we believed that this arrangement is less provocative, since it allows for more face to face contact and does not, by virtue of spatial arrangement, stimulate issues of "front seat/ back seat" or "in group/out group." Since we were experimenting, we wanted to introduce such novelties in a stepped fashion. This structure is consistent also with the recommendations of de Mare (2011). We anticipate using other arrangements in upcoming groups. Second, several members in this group utilized wheelchairs and walkers and access to chairs was greatly facilitated with the circle arrangement.

# Methods:

## Large Group Session Procedure

Residents living at this facility were privy to the overall facility schedule of activities for that specific Sunday. The large group, however, was not listed on the facility activities list in order to protect confidentiality of the group members. Therefore, the research team reminded the residents participating in the large group session two days prior to the actual session in their respective small group sessions. They were also reminded of the large group the day of the session. Attendance to the large group was entirely voluntary for the residents. Each participant expressed verbal consent to the study and provided written consent for the study. Also, the participants were verbally explained the structure and nature of the group sessions, but they were not explained the research hypothesis. The information regarding the research hypothesis was omitted in order to minimize any bias and/or perceptions that might skew the data. The consultants provided no incentive or reward for attending the large group session. Merely one verbal encouragement or prompt was initiated to recruit members to the large group. This prompt was given by one member of the consultant team to potential members (e.g., “Would you like to come to the large group session?”).

Due to mobility issues of some participants, researchers and student observers notified participants 15 minutes or more prior to the start of the session. Mobility issues ranged from psychomotor retardation, use of wheelchairs or walkers, Parkinson’s Disease, and shuffling gait due to various neurological and physical difficulties. During this time, the consultants, participants, and observers gathered in a large open room typically used as a dining and common area. Student observers were allowed to view the group from outside the group circle. The residents were familiar with the students and allowed them to observe the group and collect questionnaire data immediately after the group session.

The area where the consultants and researchers conducted the group was sufficient for the size of the group. The setting was a large dining room where a holding environment and emotionally safe atmosphere could be created and contained (Winnicott, 1971/2009). This common room was already known to participants as a comfortable location in the facility and welcoming area. Prior to the start of the group session, researchers arranged 30 chairs, plus three additional chairs for the consultants, into a large circle. While a large circle formation of chairs is not typical of the Tavistock method (de Mare, 2011), this set-up was utilized to reduce anxiety of the group due to the participants’ severity of symptoms as well as accommodate for participants’

mobility issues. This circle arrangement also is more compatible with cohesive interactions, more calming, consistent with previously conducted small group settings, and familiar to residents. De Mare (2011) posits that this circle arrangement is more conducive to the sense of dialogue that is crucial in the positive psychosocial matrix of a group having between 20-30 members. Members of the group chose their placement in the group during the session. The participants requiring assistance or exhibiting mobility issues were located near the entrance of the group circle. Researchers removed from the group circle all wheelchairs and other assistive devices for walking in order to minimize distractions during the group session. Therefore, all members were seated in chairs. At the start of the session, staff closed the doors to the room where the sessions were held. Researchers asked all residents who did not participate in the group study to remain outside of the room during the group session. Several members who utilized wheelchairs and walkers were helped by certified nursing assistants (CNAs) to obtain placement in chairs located around the group circle.

The group session started with the sounding of a Tibetan bell. This auditory cue signaled the beginning and completion of each group session. The residents of the facility are familiar with the auditory cue and recognize it as the start of a Tavistock group since it was used as a signal in the pre-existing small groups. After the cue, the group session convened for 50 minutes without a break in the session. Group sessions included three primary consultants trained in both the traditional and modified Tavistock models. These consultants were licensed psychologists and conducted previous Tavistock groups (Semmelhack, Ende, & Hazell, 2013). Consultants adhered to the modified (Semmelhack, Ende, & Hazell, 2013) Tavistock model as closely as possible. At the completion of the session, the consultants provided a 15 to 30 minute period of time as a "trauma reduction period" where members could discuss issues linked with heightened anxiety either due to the group or some other factor (2008).

Adhering to the traditional style of the Tavistock model, consultants refrained from providing the residents with a specific topic for discussion at the onset of each large group session (Bion, 1954; Colman & Geller, 1985). Consultants refrained from prompting residents during the group to discuss specific topics even during times of excessive silence.

At the completion of the large group sessions, researchers collected data regarding participant experiences through questionnaires derived from previous studies (Semmelhack, Ende, & Hazell, 2013) and generated specifically for this study. Researchers and graduate level students administered the 15 question questionnaire. This questionnaire assessed data regarding the participants' personal experience during the group session. At the end of the questionnaire, participants could provide additional comments/opinions regarding the group experiences. Graduate students and researchers collected the data after the completion of the group session and the group processing session.

## Structure of the Group Session

The structure of the large group session reflected that of small group sessions held at the facility and based on a modified Tavistock model. The large group session followed the modified Tavistock model (Semmelhack, Ende, & Hazell, 2013; de Mare, 2011). Consultants conducted a 50 minute session with no breaks during the session. Three primary consultants positioned themselves around the group circle interspersed between the participants of the group during the session. Participants discussed any topic they chose to discuss without any overt or explicit influence from the consultants. Consultants provided interpretations and comments when they felt it was appropriate for the group members. However, consultant roles fell into various orientations including: providing descriptions of group interactions and processes, commenting on thematic developments, and interpretations of comments. The roles of the consultants were not assigned and consultants changed between roles depending on the needs of the group. Additional considerations were given to contextual influences on the group including facility events, time based boundaries, and general emotional tone of the group.

Consultants and student observers would meet for 30 minutes prior to each large group session to share their personal process as it related to their work in the group, to recall the themes of the previous group, to assess any events that had occurred in the immediate and even wider context of the group and to examine their own internal dynamics as a team.

Consultants to the group reduced the structure of the group sessions to 50 minute duration in order to encourage a flowing group. This open structure also allowed for group processes and themes to emerge and participants not be influenced by consultants or facility members. However, during the first large group session, consultants introduced and explained the purpose of meeting in a large group and explained the general procedure of the group (i.e., how long the group will run, that the group is open to anyone, the group is voluntary).

At the completion of the group session, consultants and researchers provided time for the group to debrief and process the group session. This ten minute period of time allowed for the participants to ask questions, provide comments, and share experiences with other members and consultants. The debrief time was not an extension of the therapeutic Tavistock group. Rather, this time was unstructured and participants would choose to engage in the discussion or leave the room during this time.

## Group Participants

Residents living at a long-term care nursing home located in the Midwest participated in the group sessions. Participants of the group ranged in age from 42 to 75 years old. The group was comprised of both males and females diagnosed with severe mental illness (e.g., Bipolar Spectrum, Schizophrenia Spectrum). In most group sessions, more females (M = 15.33) compared to males (M = 8.67) participated in the group session. The participants resided at the facility for a minimum of one year. However, most participants resided at the facility for more than three years.

**Table 1**

*Demographics of Participants*

| | Mean | SD | % |
|---|---|---|---|
| Age | 60 | 10.5 | - |
| Attendance in Group | 24 | 1.79 | - |
| Gender –Males per Group | 8.5 | 1.64 | 36 |
| Gender – Females per Group | 15.5 | 1.05 | 64 |
| Questionnaires Completed per Group | 22.5 | 2.35 | 94 |

Participants of the large group also previously attended small group versions of the modified Tavistock sessions that other consultants conducted on a different day of the week. These small groups were comprised of 15 members or less, but the groups drew on the same set of residents. The membership of the large group sessions ranged from 21 to 26 participants. The groups were also comprised of mainly Caucasian individuals (98%) with one African American male attending a group session and one African American female attending a different session. Most participants also were diagnosed with various medical diagnoses (e.g., Type 2 diabetes, Tay Sachs, Mild Intellectual Disability) in addition to their mental illness diagnosis.

## Schedule of the Group Session

Researchers of the study conducted the large group sessions on one Sunday each month. Due to scheduling of

activities in the facility, Sunday afternoons provided to best time for the group to be conducted with little interference. Keeping a consistent time for the group sessions provided the residents structure and a predictable time for the group in order to promote a routine to avoid confusion and/or anxiety regarding timing of the group. Researchers conducted the group sessions from 1:30pm to 2:20pm including the time for set-up, session, and debriefing.

## Assessments Used in the Study

To determine any effects from the group session, the researchers recorded and examined major themes from the group sessions using a qualitative/thematic analysis and provided a non-standardized questionnaire specific for the study to the participants. The data collected for this study is qualitative and should be reviewed as such. There are few standardized assessments available to adequately assess the Tavistock model, especially for a large group design. Therefore, it was determined to be more valuable to collect qualitative data (i.e., anecdotal data, transcripts from sessions), behavioral observations, conduct a thematic analysis, and collect questionnaire data to determine the effects of the study on group participants.

During the group sessions, graduate student observers recorded behavioral observations, comments, and consultant interpretations. After the group session ended, researchers examined the observations and determined major themes occurring during the sessions. Participants also were allowed to provide any additional comments to the observers and consultants at the end of a session. The data from the behavioral observations and the anecdotal evidence is beneficial since it provides a "real" account of the experiences of participants that may not be captured using standardized assessments.

This study also utilized a non-standardized questionnaire to assess the participants' reactions and experiences. This 15-question non-standardized questionnaire provided additional objective data from the sessions. This questionnaire was designed for this study due to a lack of specific assessments assessing the variables in the study and is derived from the Current Status of Group Cohesion Scale (Treadwell, Lavertue, Kumar & Veeraraghavan, 2001) and previously used assessments (Semmelhack, Ende, & Hazell, 2013). Using a combination of items from other assessments (e.g., group cohesion scales) and novel items, the questionnaire was constructed and adapted for the long-term care residents diagnosed with severe mental illness. Participants were provided the option to answer the questionnaire on their own or with the assistance of graduate students. These accommodations were needed for some participants due to physical disabilities, verbal comprehension, and/or medical issues.

Graduate level psychology students verbally administered the participants the questions on the questionnaire. Participants were then allowed to include additional comments about the group session and rate their answers using a Likert scale range. The questionnaire questions used a 5-point Likert scale with a range of 0 to 4. The questions focused on topics relevant to group dynamics and Tavistock research. For example, these topics included level of group comfort, self-reflection and insight, group size preference, and group cohesion.

Together, these two forms of assessments allow for the researchers to identify major themes and events prevalent in the sessions. Also, the anecdotal evidence provided subjective evidence for the participants' experience of the group. Thus, the data collected examined the objective and subjective experiences of the group members to the best of their ability.

For the behavioral observations, graduate student observers recorded various overt behaviors. Shifts in facial expressions, the frequency of responses, and/or the rate of responding were some behaviors observed and collected for the study. Group participant attendance, participant drop out during the session, and changes in seating are additional factors that were observed and collected.

# Results:

After the completion of six consistent group sessions, researchers compiled questionnaire results and examined the collected data. Due to the nature of the design of the study, only the questionnaire data can be examined quantitatively. Therefore, a discussion of the results from the questionnaires will be included in this section. Please refer to later sections for thematic and process qualitative data.

## Questionnaire Results

Researchers surveyed participants of the groups directly after the completion of each group session. In order for data from the questionnaires to be included in the data analysis, participants needed to complete at least five of the six possible questionnaires. A total of 42 participants completed at least one questionnaire. However, after six group sessions, a total of 14 participants completed at least five of six questionnaires. This small sample of participants resulted from external factors (i.e., inconsistent group attendance, change in health status, refusal to complete a questionnaire, death).

**Table 2**

*Questionnaire Results*

| Variable | Mean | F | p value |
|---|---|---|---|
| Pre-group Comfort | 3.18 | 4.371 | **.047*** |
| Post-group Comfort | 3.36 | 2.066 | .183 |
| Level of Connection | 3.39 | 1.00 | .405 |
| Desire to Express Feelings | 2.82 | 0.487 | .630 |
| Desire to Express Thoughts | 2.88 | 0.664 | .538 |
| Consultants Provided New Ways of Thinking | 2.94 | 2.668 | .123 |
| Insight | 2.67 | 6.207 | **.020*** |
| Enjoyment | 3.55 | 5.945 | **.023*** |
| Group Size Comfort | 3.18 | 5.198 | **.032*** |
| Listened to by Consultants | 3.33 | .650 | .548 |
| Participation | 2.27 | 0.621 | .559 |
| Desire for Continuation of Large Group | 3.24 | 6.203 | **.020*** |
| Consultant Support | 3.03 | 0.134 | .877 |
| Group Size Preference | 1.97 | 0.485 | .631 |
| Feeling Ignored | 3.03 | 2.180 | .169 |

*$*p<.05$*

A repeated measures analysis of variance (ANOVA) was conducted examining the 15 variables of the questionnaires at three separate time intervals. From the analysis, five variables were statistically significant. These variables included: Pre-group Comfort ($F = 4.371$, $p<.05$), Insight ($F = 6.207$; $p<.05$), Enjoyment ($F = 5.945$, $p<.05$), Group Size Comfort ($F = 5.198$, $p<.05$), Desire for Continuation of Large Group ($F = 6.203$, $p<.05$). These results indicate that there were significant increases in ratings on these variables over the course of six months. As for the other variables examined, there were also increases in ratings; yet, these changes did

not meet statistical significance.
Results indicated that there were significant differences between the scores of five variables. After six sessions, the group members reported increased comfort, insight, enjoyment, and a desire for the group to continue.

Topics Covered In The Group
During the group sessions, common themes based on the residents' emotional states, common experiences, and facility events emerged. Some of these themes emerged and explored frequently including themes of power, loss, anxieties, and hopes for the future.

Many of the group themes that occurred were greatly influenced by the context of the group, recent events at the facility, and time of the year. Therefore, the second portion of the study examined the frequency of the most common themes during the group discussion. The most frequent themes that emerged over the course of the time of the group included Intense Emotions (i.e., Anxiety, Hostility, Depression), Interpersonal Relationships, Coping Skills, Human Contact, Interpersonal Roles, Existential Themes, and Suffering/Struggles. Additional themes were present. However, these themes of control, authority, and power did not emerge until later sessions.

**Table 3**
*Common Themes*

| Theme | Frequency | % |
|---|---|---|
| Communication | 3 | 50 |
| Human Contact | 4 | 66 |
| Interpersonal Relationships/Interactions | 5 | 83 |
| Interpersonal Roles | 4 | 66 |
| Intense Emotions (i.e., Anxiety, Hostility, Depression) | 6 | 100 |
| Existential Themes | 4 | 66 |
| Community | 2 | 33 |
| Safety | 2 | 33 |
| Power/Authority | 2 | 33 |
| Suffering/Struggles | 4 | 66 |
| Group Roles | 2 | 33 |
| Coping Skills | 5 | 83 |
| Trauma/Negative Life Events | 1 | 17 |
| Trust/Faith | 3 | 50 |
| Religious Themes | 2 | 33 |
| Helplessness vs. Hopefulness | 2 | 33 |
| Sense of Self/Self Themes | 2 | 33 |
| Goals | 1 | 17 |
| Control | 0 | 0 |
| Change | 0 | 0 |

# Discussion:

This study examined the effects of a modified Tavistock approach (i.e., large group application, circle formation) on a group of individuals residing in a long term skilled nursing care facility and diagnosed with severe mental illness. This study utilized a 15 question non-standardized questionnaire to assess the participants' reactions and experiences to the group process and additional objective data from the sessions. This questionnaire was designed for this study due to a paucity of specific assessments assessing the variables in the study and was derived utilizing items from other assessments (e.g., group cohesion scales) and novel items. Furthermore, the questionnaire was constructed and adapted for the long-term care residents diagnosed with severe mental illness.

As hypothesized, participants reported increased ratings on the variables assessed by the custom questionnaire. However, only five of the 15 variables appeared to achieve statistically significant increases. From the questionnaire results, the large group adaptation resulted in increased enjoyment in the group, insight, group size comfort, pre-group comfort, and a desire for the group to continue. From the thematic analysis, common themes included intense emotions (i.e., Anxiety, Hostility, Depression), interpersonal relationships, coping skills, human contact, interpersonal roles, existential themes, and suffering/Struggles.

This study has several weaknesses. There is no control group and the measures may be biased by respondents giving subjective evaluations. It must also be recalled that the participants were exposed to and experienced in the Tavistock modality in small group format having participated in such events for several years previously. However, the data of these group processes is experiential and gives other practitioners ideas as to what to expect when running such groups themselves. If it is recalled that the study is only intended to demonstrate that such a group is possible and desirable in at least one instance, then the findings are positive. These individuals with severe diagnoses were able to function and derive benefit from participating in a large Tavistock group for over a year. This is consonant with the expectations found in the writings of de Mare (2011) for example. This study demonstrates the potential utility of large Tavistock groups as a treatment modality for patients with severe diagnoses to such an extent that further studies with better controls and measures would be worthwhile.

# Conclusions:

This study furthers research on both Tavistock group approach and group therapy in long-term care facilities. Due to the nature of long-term care facilities, the study illustrates that residents in long-term care facilities experience intense emotions, concerns about existential issues, and interpersonal issues. Therefore, group approaches such as the style used in the study may be effective and beneficial for residents by providing an outlet to address some of these common themes. It should be noted that as the group sessions progressed, additional themes focusing on power, authority, community, and sense of self were beginning to develop.

While this study utilized both a questionnaire and thematic analysis as the basis for collecting data, the use of more formal assessments and analyses would be prudent. For example, future studies could include assessing levels of anxiety and/or depression before and after the completion of the adapted Tavistock group. Additionally, future studies may wish to examine the impact of community and community development in long-term care facilities using Tavistock group approaches.

## Financial Disclosures:

Dr. Diana Semmelhack is the on staff psychologist employed at the location where this study was conducted. There were no other financial incentives, grants, or donations for the study. All participation was voluntary

and no outside or private incentives were used during the study.

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