Expressive and Traditional Group Counseling Approaches: Treatment Outcomes and Patient Satisfaction in a Combined Partial Hospitalization and Intensive Outpatient Program

A dissertation presented to

the faculty of

The Gladys W. and David H. Patton College of Education of Ohio University

In partial fulfillment

of the requirements for the degree

Doctor of Philosophy

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April 2021

This dissertation titled

Expressive and Traditional Group Counseling Approaches: Treatment Outcomes and Patient Satisfaction in a Combined Partial Hospitalization and Intensive Outpatient Program

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Abstract

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Expressive and Traditional Group Counseling Approaches: Treatment Outcomes and Patient Satisfaction in a Combined Partial Hospitalization and Intensive Outpatient Program

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There is limited research on effectiveness studies and patient satisfaction for partial hospital and intensive outpatient programs. The goal of this study was to assess if the severity of mental health symptoms decreased and functioning increased in clients who attended a combined partial hospitalization (PHP) and intensive outpatient program (IOP) in a Midwestern rural hospital over a three-year period. It was hypothesized that there would be a decrease in the severity of symptoms and an increase in functioning between admission and discharge. Symptom and function improvement were defined by lower total scores on the Behavior and Symptom Identification Scale (BASIS-32), comparing data collected at admission to data collected just prior to discharge. Analyses of a pre and post-test using the BASIS-32 total scores with a paired *t*-test indicated a statistically significant reduction in overall scores from admission to discharge. Patient satisfaction was comparable to the national average in the United States. The results of this study are beneficial to various stakeholders, including counselors, counselor supervisors, counselor educators, the medical community, current and potential persons in PHP or IOP and their supports, payer sources, and the Association for Ambulatory

Behavioral Healthcare (AABH). Implications of the study, limitations, and suggestions for future research, are presented.

Dedication

This writing is dedicated to the loving memory of my late husband, E. Larry Sauselen. Words cannot express how much I wish you were here. You continue to be with me in spirit and in every decision I make. I will love you forever.

I would also like to dedicate this work to Mr. David J. Dirr and Mrs. Caryn L. Long. Thank you for consistently providing containment, support, structure, involvement, and validation. My love and passion for this work is because of both of you. I aspire to lead by your examples every day, both professionally and personally.

To my parents, Jack J. and Nancy S. Nemeth, to my brother, Nathan Joe Nemeth, my grandparents, and my sister-in-law, Brenda Butler. You all have been guiding lights since day one. There is so much to say and not enough space. Please know that I love you with everything that I have. Your presence, support, encouragement, and unwavering love are immeasurable.

To my nieces and nephews, may all your dreams come true. I will always be in your corner and I love you.

Acknowledgments

In no particular order, I am indebted to many. I would like to thank my program and dissertation advisor, Dr. Christine Suniti Bhat. This has been a very long journey and I truly could not have done it without your support, belief in me, and your encouragement. Thank you for your knowledge and expertise, your ethic, your commitment, and your patience. I would also like to thank my dissertation committee, Dr. Yegan Pillay, Dr. Mona Robinson, and Dr. William Larson. I appreciate your feedback, your guidance, your encouragement, and your kindness during this process. Both academically and personally, you have shaped me in many ways.

To Ms. Sally Hatfield and Dr. Cynthia Tindongan: Thank you for your time, expertise, and feedback. I appreciate your willingness to assist me in this process. Also, I want to thank Dr. Porsche Ruengvirayudh for your time and humor. Your high expectations to get me to my end goal, coupled with enthusiasm and a student-centered approach, has meant so much to me and gave me confidence to see this to the end.

I would like to extend a huge thank you to Dr. Laura Rush, Mr. Thomas Whitlow, and Ms. Morgan Davis. Your investment, support, guidance, and input were tremendous!

In the early part of my writing, I sought out leaders in my field and would like to thank Mr. Larry Meikel and Mr. Tom Miller for helping me to understand the need for this research and reinforcing my hope to contribute to Partial Hospital and Intensive Outpatient Programs, even if it is in a very small way. Additionally, I would like to thank past and current members of the Ohio Chapter of the Association for Ambulatory

Behavioral Health for your input, also in those early days of writing. Thank you all for your continued commitment and advocacy to PHP and IOP. Keep up the fight!

To my current and past co-workers, I could never repay you! To Jennifer Eaton, MAAT, LPC. You have changed my life in more ways than you will ever know! You are truly a gift to many, including to me on both a personal and professional level. I admire your love for Art Therapy and your investment in protecting the sanctity of healing through creativity. I am proud to call you my friend. To Cathleen Johnson, Angel Milligan, and Cheryl Schmidt. I am so grateful for your many years of friendship and for your encouragement, love, and support all these years.

I would also like to thank Mrs. Erin Lucas and Dr. Sherry Shamblin for your unwavering support, your visions for a better future for the human race, and your outstanding leadership. Your giving spirits and time invested in me is something I will always be grateful for and never forget. I hope that you will never underestimate your impact.

To my cohorts, Dr. Bilge Sulak and Dr. James Alexander Reed. I am so proud of you both! May your careers and lives be everything you hope for and more.

I would be remiss to not mention Dr. Shravan Agrawal, Dr. Michele Stokes, Kelly Hopkins, Amy Minser, Jodi Lewis, Dr. Dallas Erdmann, Dr. Bipin Desai, and Dr. James Clark. The support, encouragement, leadership, and guidance from all of you has meant so much and I am so thankful for all that you have done for me. I have learned so much from each of you!!

To my friends and extended family. Your love and support mean everything to me. I would like to say a special thank you to my grandfather, Jim Cunningham, and to Nathan Nemeth, George Nemeth, Carl Prichard, Bear Elliott, Tammy Borders, Deborah and Edward Redmon, John Bowley, Sara Nemeth, Amy Starkey, Mary Jo Boler, and the Butler/Sauselen families.

Table of Contents

Page

Abstract 3
Dedication 5
Acknowledgments 6
List of Tables 11
List of Figures 12
Chapter 1: Introduction 13
Partial Hospitalization and Intensive Outpatient Treatment Programs 14
Creative and Art-Influenced Approaches to Group Counseling in PHPs 18
Purpose of the Current Study 19
Problem Statement 20
Research Questions 21
Benefits and Limitations of the Study 23
Delimitations and Organization of the Study 23
Personal Statement 24
Definition of Terms 25
Summary of the Contents by Chapter 27
Chapter 2: Literature Review 29
Evolution of Mental Health Treatment 29
Defining Group Work 33
Group Formulation and Facilitation 35
Clinical Staff Impact on Therapeutic Milieu 40
Benefits of Traditional Group Counseling 42
Benefits of Art/Expressive Therapy in Group Counseling 43
Therapeutic Milieu 46
Gunderson's Therapeutic Processes and Application in PHP 47
Therapeutic Factors in Group Counseling 49
Suggestions for Creating a Supportive Group Environment in a PHP Setting: Theory to Practice 54
Description of a Partial Hospitalization Program 58

Description of Studied PHP/IOP Site 63
Two Group Counseling Examples Specific to the Studied Site 70
Previous Studies on Partial Hospitalization Programs 76
Additional Studies on Patient Satisfaction 80
Chapter 3: Methodology 83
Research Objectives 84
Variables Used in the Study 85
Sampling Plan and Procedures 87
Instrumentation and Data Collection Procedures 88
Sociodemographic Variable Questions 89
Behavior and Symptom Identification Scale-32 92
Perception of Care Surveys 95
Research Questions 96
Data Analysis Procedures 97
Chapter 4: Results 100
Research Questions 100
Demographic Information and Clinical Characteristics of the Sample 102
Findings Reported for each Research Question 107
Chapter 5 Discussion 115
Overview of the Study 115
Review of Findings 117
Overall Symptom and Function Improvement 118
BASIS-32 Subscale Results 119
Patient Satisfaction 120
Implications 123
Limitations of the Study 127
Recommendations for Future Research 128
Conclusion 129
References 131
Appendix A 143
Appendix B 144

List of Tables

Page

Table 1 Demographic Sample and Clinical Characteristics.....103

Table 2 Age and Number of PHP and IOP Days 104

Table 3 Subscales 1-5 and Overall Score at Admission and Discharge.....106

Table 4 BASIS-32 Subscales 1-5 and Overall Scores at Admission and Discharge: Paired Samples Test 113

Table 5 Total Scores for Perception of Care from 2013-2015 and National Average...114

List of Figures

Page

Figure 1 BASIS-32 Subscales 1-5 Admission and Discharge Scores. 106
Figure 2 BASIS-32 Overall Admission and Discharge Scores..... 108

Chapter 1: Introduction

This chapter provides an overview of the study, including a brief survey of the current literature, a statement of the problem, research questions, significance of the study, delimitations of the study, and definitions of key terms. Existing treatment approaches fail to adequately address the global crisis of mental health care. One-third of adult disabilities stem from mental health issues, including major depression and bipolar disorder, among others (World Health Organization, 2018). “Mental illness is closely associated with poverty, wars, and other humanitarian disasters, and in some cases, leads to suicide, one of the most common causes of preventable death among adolescents and young adults” (Lake & Turner, 2017, p. 17). Massive psychological, social, and occupational costs are associated with depressed moods, which is the leading cause of disability in the United States for those aged 15-44, with annual losses in productivity from thirty to fifty million dollars (Kessler, 2011).

To help support the need for continued mental health care, it is important to understand the impact if this is not made a priority. Suicide is currently the second leading cause of death in 15 to 29-year-olds, resulting in enormous social disruption and losses in productivity (Kessler, 2011; Lake & Turner, 2017). Between ten and twenty million depressed individuals attempt suicide every year and approximately one million complete suicide (Lake & Turner, 2017). The World Health Organization (WHO) has declared depression to be the third leading cause of disability worldwide (WHO, 2018). Further, Lake and Turner (2017) point out that:

> In developed countries, elderly individuals, minorities, low-income groups, uninsured persons, and residents of rural areas are less likely to receive adequate mental health care, and most people with severe mental health problems receive either no treatment or inadequate treatment of their disorders" (Lake & Turner, 2017, p. 18).

Keeping the aforementioned issues in mind, it is important to understand the continuum of care for persons with mental health disorders.

The continuum of services for mental health care ranging from most severe to least severe, is as follows: inpatient hospitalization, residential treatment, partial hospitalization, intensive outpatient, in-home/family, preservation, outpatient, and self-help (Houvenagle, 2015). Those who are experiencing acute psychological distress but do not meet the criteria for inpatient hospitalization are often best served in a Partial Hospitalization (PHP) or Intensive Outpatient Program (IOP). There is an "increasing need to provide less restrictive and more cost-efficient levels of care…while keeping the patients at home" (Wise, 2003, p. 405). Wise (2010) reported that that 56% to 74% of patients treated in these levels of care are expected to improve.

Partial Hospitalization and Intensive Outpatient Treatment Programs

Partial hospitalization is an intermediate level of care designed for those experiencing acute psychiatric symptoms that temporarily interfere with their ability to function in their given capacity. Partial hospitalization programs (PHP) offer a time-limited, therapeutic method of treatment that is an alternative to inpatient hospitalization and can also be a step-down from an inpatient level of care, with the goal often being to

move participants back to their previous level of functioning as much as possible. PHPs are:

> structured to provide intensive psychiatric care through active treatment that utilizes a combination of clinically recognized…services…that closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation (Center for Medicare and Medicaid Services [CMS], 2014, p. 6).

To further define the function of a PHP, they are designed to, "provide intensive, short-term treatment when symptoms are too severe to be managed on an outpatient basis, but do not reach the threshold for inpatient admission" (Hill, 2011, p. 279). Additionally, PHPs offer, "coordinated, and structured clinical services within a stable therapeutic milieu…and [offer] the flexibility to deal with a very wide range of conditions (Association for Ambulatory Behavioral Healthcare [AABH], 2015, para. 2). Furthermore, PHPs "provide an important 'bridge'…that allows patients to maintain independence and return home at the end of the day, while also receiving intensive treatment and support" (Forgeard et al., 2018, p. 212).

Traditional group therapy, art therapy, and partial hospitalization programs were all first introduced during the 1930s and the 1940s (American Art Therapy Association [AATA], 2012; Hoge et al., 1993; Khawaja & Westermeyer, 2010; Parker & Knoll, 1990; Riley, 2001; Soref & DeVries, 2005; Yalom, 1995). Partial hospitalization programs (PHP) increased dramatically from the 1970s to the 1990s (Neuhaus, 2006), mostly due to the community mental health movement and its call for treatment to be in close

proximity to a patient's community and to be cost effective (AABH, 2015; Khawaja & Westermeyer, 2010; Murer, 2007).

Unfortunately, PHPs have not had the staying power they once held thirty to forty years ago, and many programs have closed across the United States. At the time of this writing, there were approximately 400 PHPs in operation in the United States (Forgeard et al., 2018). There is no known research on the number of total programs that have been open at some point from the inception of PHPs to now. The Association for Ambulatory Behavioral Healthcare ([AABH], 2019) confirmed:

> We [AABH] do not have data on the number of PHPs when they were first introduced. We know that the numbers have gone down from about 1700 programs at the peak of PHPs to about 500 programs as PHPs have closed" (L. Meikel, personal communication, March 22, 2019).

This is due to, in part, the guidelines enforced by the Center for Medicare and Medicaid Services (CMS) and programs not adhering to the protocols for partial hospital level of care. PHP's continue to be under scrutiny as a result of an investigation in the late 1990's. This is discussed in much more detail in Chapter 2.

To briefly define partial hospitalization, it is considered a level of care for mental health symptoms that are at an acute level. While hospitalization is possible without this intervention and PHP can be utilized as a step down from inpatient care for mental health, it is important to understand that not all patients that are hospitalized would necessarily step down to a PHP level of care. The reason for this is because PHP's have admission criteria that not all patients would meet. PHP may also be considered for someone that

requires a more intense level of care than their ongoing outpatient services are able to provide. Persons in a PHP require a:

> comprehensive, structure, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which [acutely] interferes with multiple areas of daily life, including social, vocational, and/or educational functioning…[persons] must be able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a PHP program (CMS, 2014, p. 6).

Intensive outpatient programs (IOP) are considered a step down from PHP or a level of care that is higher than ongoing, outpatient services (i.e., provides more intense services than weekly or every other week counseling sessions). The most common, primary diagnoses treated in this level of care (comparable to site studied) are bipolar disorder and major depression. Often, post-traumatic stress disorder, and generalized anxiety disorder are treated secondarily.

Individual and Group Counseling in PHP/IOP.

The primary mode of treatment for PHP and IOP is group therapy, and the length of stay varies based on individual needs. All individuals admitted to either level of care are required to have an individualized treatment plan that:

> according to current practice guidelines, [has]… treatment goals [that] should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission" (CMS, 2004, p. 6).

Additionally, a psychiatric evaluation and medical certification for the respective level of care is required within twenty-four to forty-eight hours of admission. Given recent updated regulations enforced by the Center for Medicare Services (Meikel, 2017), PHPs are required to provide weekly individual counseling sessions, weekly psychiatric sessions (which include medication management services while patients are in the program), and case management services as needed. Those admitted to the PHP level of care are required to be scheduled for twenty hours of services per week and must be able to tolerate the milieu emotionally and cognitively. Those admitted to IOPs are required to have individual counseling sessions once per month (additional sessions are permitted as needed) and are to be seen by the admitting physician once within forty-eight hours of admission and again as needed (or at least one time per month after admission).

Creative and Art-Influenced Approaches to Group Counseling in PHPs

The Center for Medicare and Medicaid Services (CMS) requires a multimodal treatment regimen as part of PHP. "Services may include individual or group psychotherapy, activity or expressive therapies (non-recreational), family counseling, psychoeducation, and appropriate medical care related to mental health treatment" (CMS, 2014, p. 7). It is important to note that all participants in the study were exposed to art and expressive therapy groups as part of the combined PHP/IOP treatment. While still quite limited, most research studies and literature on PHPs center on using traditional group counseling theories and methods. Furthermore, while creativity in counseling is a growing trend in individual and group counseling research (Slayton et al., 2010), little attention has been on PHPs that offer both traditional and art/expressive counseling

approaches (Drapeau & Kronish, 2007). In addition, "partial hospitalization is a service modality that some have suggested is incompatible with both evidence-based and recovery-oriented treatment" (Yanos et al., 2009, p. 43). Also:

> "[b]ecause existing research in PHPs is limited, future scholarship in this area will not only help improve intervention strategies targeting the specific needs of this clinically understudied population, but also help update the literature on acute psychopathology and high-risk populations in general" (Forgeard, Beard, Kirakosian, & Bjorgvinsson, 2018, p. 207).

There has been a call to reinvigorate interest in PHPs as a viable and necessary level of care not only for their cost effectiveness, but for the many other benefits they provide for patients, their families, and their communities (AABH, 2015; Khawaja & Westermeyer, 2010; Murer, 2007; Soref & DeVries, 2005).

Purpose of the Current Study

Given this appeal to re-invigorate interest in PHP as a viable and necessary level of care, this research aimed to address the following areas. The goals of the study were to expand research on the effectiveness of group counseling and creative interventions offered in a PHP, and to thus focus more attention on PHPs in general and those programs that offer both traditional and art/expressive counseling approaches. In addition, this effectiveness study examined the symptomology of participants at the time of admission and discharge to a combined PHP and IOP that employed traditional and creative approaches to group counseling. I gained access to archived data, including demographic information, symptomology, and level of functioning as measured by the

Behavior and Symptom Identification Scale (BASIS-32) at the time of intake and discharge from the program for patients admitted and discharged from 2013-2015. Further, I examined participants' level of satisfaction by their responses to the Perception of Care Surveys, sanctioned by the American Ambulatory Behavioral Health (AABH) organization, which was compared against national averages of other PHP/IOPs. The national average scores were calculated by the Spectrum of Statistics. These scores were compared to the results of the program that was studied and data from responses to thirteen categories are presented.

The BASIS-32 results were examined using historical data from participants admitted and discharged from the combined PHP/IOP over a three-year period. Similarly, the Perception of Care Surveys (a satisfaction survey) were examined using historical data from participants in the combined program over a three-year period. The data were in aggregate form and no data were linked to any individual participants.

Problem Statement

Effectiveness studies seek to "answer how well patients fare under treatment as it is actually practiced in the field and yield useful and credible information that can empirically validate psychotherapy" (Granello et al., 1999, p. 53). There is insufficient research on effectiveness studies for partial hospital and intensive outpatient programs and patient satisfaction. The main goal of this effectiveness study was to address this gap in the literature by increasing the knowledge base of treatment outcomes and patient satisfaction in partial hospitalization and intensive outpatient programs. The research questions assessed if the severity of mental health symptoms decreased and functioning

increased in those that attended the combined partial hospitalization and intensive outpatient program. Additionally, demographic information, such as gender, age, race, employment status, and presence of dual diagnosis (defined as a mental disorder combined with a substance abuse disorder), were examined to understand and describe participants in the data set. A detailed description of the program, including its structure, history, staff make-up, and program admission requirements, is provided in Chapter Two.

Research Questions

The following research questions and hypotheses guided this empirical study:

RQ1: Will adults in a PHP/IOP program that utilizes both traditional and expressive group counseling show a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge?

H_o: Adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by the total scores on the BASIS-32 total.

RQ2 :Will positive changes occur in relation to self and others, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to self and others as measured by Subscale 1 on the BASIS-32.

RQ3: Will positive changes occur in daily living and role functioning, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in daily living and role functioning, as measured by Subscale 2 on the BASIS-32.

RQ4: Will positive changes occur in depression and anxiety, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in depression and anxiety, as measured by Subscale 3 on the BASIS-32.

RQ5: Will positive changes occur in impulsive and addictive behaviors, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in impulsive and addictive behaviors, as measured by Subscale 4 on the BASIS-32.

RQ6: Will positive changes occur in relation to symptoms of psychosis, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to symptoms of psychosis, as measured by Subscale 5 on the BASIS-32.

RQ7: Will the level of patient satisfaction exceed the national average during a three-year period (2013-2015)?

This is a simple comparison and thus there is no hypothesis related to question seven.

Descriptive statistics of central tendency and variability, including gender, age, race, employment status, and presence of dual diagnosis (defined as mental disorder combined with substance abuse disorder), were included in the study. A description of the program of study, including its structure, history, clinical team make-up, and program admission requirements is provided in Chapter Two.

Benefits and Limitations of the Study

Conducting an effectiveness study has multiple benefits, including more inclusion criteria, which can result in a larger patient/participant pool, a variety of treatment settings, and identification of clinical needs (Moller, 2011). Effectiveness studies also account for higher external validity and increased application to real world treatment settings, and they can contribute to policy development (Granello et al., 1999; Moller, 2011; Waltman, 2018). Although there are many benefits, these types of studies can also result in limitations of the research. Limitations of effectiveness studies include limited internal validity and such studies do not always allow for clinical comparisons (Moller, 2011; Waltman, 2018).

For the current study, archived data from a period of three years (2013-2015) was analyzed, as it was during this time frame that the BASIS-32 was administered to all participants pre- and post-treatment at the PHP/IOP program. The population studied was largely homogeneous regarding race, which is understandable given the location of the facility. Thus, generalizability may be narrowed to participants attending a combined PHP/IOP versus programs that are separated and may track outcomes after discharge from each program in racially homogeneous areas with small program sizes (ten or less participants at a time). Additionally, archived data limits the ability to manipulate variables.

Delimitations and Organization of the Study

A thorough review of archived data was conducted from a three-year period to obtain treatment outcomes of participants that attended a combined PHP/IOP in

Midwestern United States. For the purpose of this study, data analyzed were delimited to participant data from a three-year period (2013-2015). The examined data included information from 171 participants. Data from participants who did not complete measures at both the start and end of treatment were omitted from the study. Treatment outcomes were assessed by comparing the BASIS-32 scores of participants at the time of admission to PHP or IOP and at the time of discharge from PHP or IOP.

In brief, the BASIS-32 uses a 5-point Likert scale, measuring the level of difficulty the person in treatment is having in the following areas: relation to self and others, depression and anxiety, daily living and role functioning, impulsive and addictive behavior, and psychosis (McLean Hospital, 2016). These results were retrieved from the program being studied, along with demographic information of participants. Participant satisfaction surveys were also studied. All results obtained were analyzed, using quantitative measures to describe the responses of the sample, along with central tendencies.

Personal Statement

I am deeply passionate about the work in partial hospital and intensive outpatient programs and this is the work I have been involved in for over a decade. Despite a personal passion, I aimed to conduct the research from an objective standpoint. I was interested in carrying out this study to enhance the spotlight on this important work, to demonstrate its impact on those served and the unique experiences it provides, and to contribute to the study of group counseling in PHP/IOP in general. It was my hope to

produce results that would support PHP/IOP as a viable treatment service that is much more than a cost-effective alternative to inpatient care.

Definition of Terms

The following terms are defined to better understand the research study:

1. Behavior and Symptom Identification Scale (BASIS-32): An assessment that measures a change in symptoms and level of functioning from a participant's perspective. It is a brief yet comprehensive instrument that cuts across diagnoses by identifying a wide range of symptoms and problems that occur across the diagnostic spectrum (Eisen & Grob, 1986).
2. Dual Diagnosis: Presence of a substance abuse and a mood disorder.
3. Intensive Outpatient Program (IOP): A level of care for that is less intense than the partial hospitalization level of care, but more intense than regular outpatient counseling. Typically, participants attend group programming three to four days per week, not to exceed eleven hours per week (CMS, 2014).
4. Expressive Arts Therapy:

   The arts (art therapy, music therapy, dance/movement therapy, and drama therapy) are used to facilitate growth and healing and to create social change for both individuals and communities. Expressive arts therapists are certified, credentialed, or licensed therapists who are specialists in using the arts (or one specific artistic medium) as therapy" (Gombert et al., 2017, p. 20).

   Milieu: Any environment or culture in which a person lives or is a part of (Gunderson, 1978; Houvenagle, 2015).

5. Partial Hospitalization (PHP): An intermediate level of care for someone needing intensive treatment beyond what can be offered in outpatient settings for mental health related symptoms (Forgeard, Beard, Kirakosian, & Bjorgvinsson, 2018).
6. Pre-treatment: For the purpose of this study, pre-treatment is defined as understanding a participant's assessment scores the first day of admission to the combined PHP/IOP.
7. Post-treatment: For the purpose of this study, post-treatment is defined as understanding a participant's assessment scores the day of discharge from the combined PHP/IOP.
8. Spectrum of Statistics: Independent consulting firm that analyzes the data from the Perception of Care surveys. This firm provides individual results for PHP and IOP programs and compares each program to the national average (United States).
9. Therapeutic Factors: Eleven factors that drive therapeutic change in a group setting, through "interplay of human experiences" (Yalom, 1995, p. 1). These therapeutic factors will be described in more detail in Chapter 2.
10. Therapeutic Milieu: An active therapeutic agency to promote and facilitate positive changes in specified directions. The therapeutic milieu is developed within a system when a need is felt and the value is recognized (Gunderson, 1978, p. 332).
11. Therapeutic Processes: Five therapeutic processes to guide programs to create a therapeutic milieu, including containment, support, structure, involvement, and validation (Gunderson, 1978).
12. Treatment Plan: A formal document/plan that outlines goals, strategies, and tasks to move participants towards progress in treatment (Houvenagle, 2015).

Summary of the Contents by Chapter

This chapter included an overview of the study. The study site was a rural hospital setting in the Midwestern region of the United States. The primary goal of the study was to examine the symptomology of participants at the time of admission and discharge to a combined PHP and IOP that employs traditional and creative approaches to group counseling. In addition, this chapter provided a brief examination of the current literature, statement of the problem, research questions, the significance of the study, study limitations, delimitations to the study, and definitions of key terms.

In Chapter Two, there is focus on how historical and current needs for mental health reform have been and are being addressed, and how partial hospital and intensive outpatient programs are meeting some of the need. Definitions of group work, formulation, and facilitation, discussing these in detail, as well as the benefits of both traditional group counseling and art and expressive therapies in group counseling settings are discussed. A description of Yalom's (1995) therapeutic factors and their importance in group counseling settings is included. Gunderson's (1978) elements of therapeutic process, suggestions for creating a supportive group environment, and the significance of therapeutic milieu to the PHP/IOP setting are introduced. Furthermore, Chapter Two presents a literature review of previous studies focused on partial hospital programs, as well as further defining the partial hospital level of care, and identifying any gaps that existed in the literature, to help support the need for further research in this area. Finally, Chapter Two focuses on providing a description of the program studied, along with two detailed descriptions of group examples that are specific to the site of study.

Chapter Three describes the methodology used in the study of archived data of the described program. Additionally, the outcome measures used will be described in detail, discussing the history, purpose, and the strengths and limitations of the measures used. The information in Chapter Four are the results of the analyses and Chapter Five presents the review of findings, the limitations of the study, implications for various stakeholders, and recommendations for future research.

Chapter 2: Literature Review

Evolution of Mental Health Treatment

Mental health treatment has evolved over the last century, and many efforts are still being made to improve the care provided to people that struggle with mental health or phase of life problems. Historically, the options for psychiatric care were limited to institutions, insane asylums, a psychiatrist's office, admission to a state psychiatric hospital, or in some cases, prisons (Beers, 1917; Brown, 1981; Goldman & Morrisey, 1985; Gollaher, 1995; Murer, 2007). Stays in these settings would last for several months or years, and frequently the conditions were deplorable and included measures such as several hundred hours in straitjackets, solitary confinement in padded cells (Beers, 1917), many months of minimal human contact, and denial of visits from family and loved ones (Murer, 2007). Other measures endured by psychiatric patients included being force fed medications via extreme procedures, such as inserting medication through a rubber tube in the nose of the person, restraint, or physical abuse. No advocates for the person were contacted, and when the advocates would call to inquire, the calls often went unreturned or unanswered.

Care for mental illness would also take place far away from a person's home community, making contact with supports nearly impossible for the person struggling with mental health issues (Beers, 1908; Grob, 1966, 1994; Murer, 2007; Parry, 2010). Electroconvulsive therapy (ECT), lobotomies, and ice baths were other courses of treatments implemented for psychiatric care (ECT is still utilized in a more responsible and civilized manner).

More humane efforts to treat mental illness were needed. As care was reformed over many decades, cost effectiveness, in part due to very long stays in institutions or hospitals, became a concern as well (Neuhaus, 2006). In addition, providing community-based care to people with mental health issues to "restore maximum independent living as rapidly as possible, using the appropriate level of care for the appropriate illness" (Murer, 2007, p. 48) was critical, as not everyone meets criteria for a hospital stay or, historically speaking, admission to an institution for long periods of time.

Current treatments have strong, more patient-centered, evidenced based practices and are more likely to focus on autonomy and recovery (Drake et al., 2003). Additionally, the introduction of group therapy and intermediate levels of care, such as partial hospitalization and intensive outpatient programs also contributed to progress in reform. The inclusion of art and expressive therapies to group settings also addressed a way to meet the needs of people that benefitted from creative expression as a means of healing and recovery.

Many strides have been made in mental health care reform, including the introduction of group therapy and intermediate levels of care, such as partial hospitalization (Goldman & Morrisey, 1985; Gunderson, 1978; Ogrodniczuk & Piper, 2001). Additionally, the inclusion of art and expressive therapies in group settings addressed a way to meet the needs of people who benefitted from creative expression as a means of healing. Traditional group therapy, art therapy, and partial hospitalization programs (PHPs) were all first introduced during the 1930s and the 1940s (American Art Therapy Association, 2012; Hoge et al., 1993; Khawaja & Westermeyer, 2010; Riley,

2001; Yalom, 1995). The number of PHPs increased dramatically from the 1970s through the mid-1990s, mostly due to the community mental health movement and its call for treatment to be in close proximity to a patient's community and to be cost-effective (Khawaja & Westermeyer, 2010; Murer, 2007).

PHPs have decreased in number compared to how many were functioning forty to fifty years ago, and since 1999, many programs have closed across the United States. According to Leung et al. (2009), the Center for Medicare and Medicaid Services (CMS) noticed a trend in the mid-1990s that "both utilization and costs of PHPs increased dramatically. From 1995 to 1997 Medicare payments to PHP providers more than doubled, from $245 million to $550 million" (p. 3). This trend prompted an investigation and it was discovered that of those payments, 91% of PHP units billed did not meet Medicare requirements, 73% of the claims paid were unallowable and 19% were deemed highly questionable. The inquest of five U.S. states also found that 60% of those admitted to PHPs did not meet criteria for this level of care (i.e., lower level of care would have been sufficient), and 79% of the units of services were not reimbursable under CMS requirements. These findings from CMS prompted "more stringent criteria…to reduce confusion about the intent of the benefit" (p. 6).

Reasons for program closures were likely due to a call for more rigorous requirements and further defining what a PHP level of care is and what it is not. Additionally, PHPs may have been chosen as the next step for a patient as a cost-effective measure. While there is benefit in cost-effectiveness, this does not always equal best practices if this is the only reason for admission to a lower level of care (i.e., moving a

patient from a more costly inpatient or residential setting to a PHP): “While the focus on measuring effectiveness has been cost containment; treatment outcome and client satisfaction also must be measured to ensure that the quality of mental health care is not compromised by cost containment policies” (Granello et al., 1999, p. 51). There has been a need identified to re-invigorate interest in PHPs as a viable and necessary level of care not only for their cost effectiveness, but also for the many other benefits they provide for patients, their families, and communities.

Most research studies and literature on partial hospitalization programs (PHPs) focus on using traditional group counseling theories and methods (Beard et al., 2016; Horvitz-Lennon et al., 2001; Ogrodniczuk & Piper, 2001; Schene, 2004; Zipfel et al., 2002). Furthermore, while creativity in counseling is a growing trend in individual and group counseling research, little attention has been devoted to PHPs that offer both traditional and art/expressive counseling approaches. The goal of this research was to undertake a program effectiveness study of a PHP offering both traditional group counseling and expressive arts therapy, utilizing archived data. Ultimately, I aimed to answer the question: “In what ways have clients improved as a result of participating in the combined PHP/IOP program?” A comprehensive review of the literature focused on the benefits of partial hospitalization, traditional group counseling, and art/expressive therapy in groups are included in this chapter. Additionally, a thorough description of PHP/IOP at the study site that combines traditional counseling and art/expressive therapy is presented, along with examples of two groups that utilize art therapy and expressive therapy in a partial hospital setting.

Defining Group Work

Group work, in a general sense, can be defined as "a collection of two or more individuals who meet face to face or virtually in an interactive, interdependent way, with the awareness that each belongs to the group and for the purpose of achieving mutually agreed-on goals" (Gladding, 2016, p. 2). The Association for Specialists in Group Work (ASGW) also defines group work as:

> A broad professional practice involving the application of knowledge and skill in group facilitation to assist an interdependent collection of people to reach their mutual goals which may be intrapersonal, interpersonal, or work-related. The goals of the group may include the accomplishment of tasks related to work, education, personal development, personal and interpersonal problem solving, or remediation of mental and emotional disorders" (ASGW, 2000, pp. 2-3).

CMS states that a group must consist of three or more persons, and for partial hospitalization and intensive outpatient programs, the maximum number of group participants is ten (Meikel, 2019).

In addition to these definitions of groups, there are also several types of groups, as well as different ways of facilitating them. "Group experts do not agree on [what manner]…groups should be conducted. Opinions vary widely on the role of the members, the role of the leader, the appropriate tone, and the use of theory in the group" (Jacobs et al., 2016, p. 13). Different group types include, but are not limited, to the following: guidance/psychoeducational groups, counseling/interpersonal problem-solving groups, psychotherapy/personality reconstruction groups, and task/work groups, among

many others (ASGW, 2000; Gladding, 2016; Jacobs et al., 2016). A brief discussion of psychoeducational, counseling, and psychotherapy groups will follow.

Psychoeducational groups seek to teach or provide information about a topic or issue (Gordon & Kenny, 2018). For example, this type of group might include areas such as assertiveness training, stress management, coping skills for grief/bereavement, anger management, and so on. The leader of the group is viewed as the primary educator, but input from group members is also encouraged. Psychoeducation has been deemed to be an evidenced-based practice in group settings. In a literature review conducted by Gordon & Kenny (2018), they reported the following benefits to this type of group counseling: improved quality of life, increased tolerance of distress, and reduced symptomology (Lukens & McFarlane, 2004); eliminated need for higher levels of care, such as inpatient hospitalization; (Chien et al., 2012); increased self-worth among participants (Solomon et al., 1996), as well as increased social connectedness and decreased psychological stress (Pharoah et al., 2010); and decreased incidents of relapse and help for participants managing and/or reducing levels of crises and managing life challenges (Lukens & McFarlane, 2004).

Counseling groups are good for those experiencing short-term or ongoing problem areas and are more direct in helping members view situations from a different perspective and adjusting behaviors. This type of group is conducted in a therapeutic manner and the environment is more intimate, far less educational, and strongly encourages members to be more affective (Gladding, 2016). Group psychotherapy is very similar to group counseling, but more specifically it addresses “personal and

interpersonal problems of living, remediate perceptual and cognitive distortions or repetitive patterns of dysfunctional behavior, and promote personal and interpersonal growth and development among people who may be experiencing severe and/or chronic maladjustment" (ASGW, 2000, p. 4).

Content and process are also two important concepts to be aware of as they relate to group work. Content in group work refers what is being said during a group. This includes words spoken, topics discussed, and issues that arise out of discussions during the group (Puskar et al., 2012; Yalom, 1995). Process, on the other hand, deals with what stems from the content being discussed and occurs in the here and now of the group counseling session. Process considers the "manner in which [messages are] conveyed, the actual impact, and the intended impact" (Puskar et al., 2012, p. 226). It also assists the group in examining their communication with one another and "what that communication reveals about the relationship has to the group, between clusters of members, between the members and the leader, and the members as they relate to the task of group" (Puskar et al., 2012, p. 226). Jacobs et al., (2016) suggests that group counselors need to consistently have a pulse on both content and process. "Not focusing on process can lead to a very superficial group when dynamics exist such as members dominating the group, members not trusting each other; or members feeling attacked, judged, or inferior" (p. 264).

Group Formulation and Facilitation

Group formulation can take on different facets. Those in charge of the group will need to decide on several factors before forming one. Although the focus of this study is

on groups in a partial hospital setting, a brief discussion about group formation and facilitation will be addressed and a specific discussion about group formation and facilitation in a partial hospital program follows. Formation of a group involves careful planning on behalf of the group leaders/facilitators. Facilitators will decide the purpose of the group, whom it will serve, how to screen and select members, group size, length of group, frequency, objectives, whether the group is open or closed, its structure/format, and ways in which the group will be evaluated (Corey, 2015; Jacobs et al., 2016). "Leader preparation at [the] formative phase is crucial to the outcome of a group…[Vague or unclear expectations may result in] unnecessary floundering" (Corey, 2015, p. 71).

Once the group is formed, there are typically several stages that take place. Again, in general, these stages take place sequentially in a closed group, however, in an open-ended group, the stages may be occurring simultaneously, dependent on members' entry into the group. In an open-ended group or group program, such as partial hospitalization, some stages may never occur, and some may be accelerated. For example, because PHPs have up to four groups occurring on a daily basis (due to the requirements of PHP as a level of care), the beginning stages of group may quickly progress in a day or two, while other groups that meet weekly may experience a slower progression to the next stage of group. It should be noted that groups, "will not evolve through various stages because members will always be at different [and leaders should] develop ways of introducing new members that do not detract from the flow of the last session" (Jacobs et al., 2016, p. 50).

Several perspectives exist regarding the stages at which groups operate, which can vary, dependent on the approach being used. The initial or beginning stages of a group generally deal with apprehension among group members, reviewing members' goals and contracts, specifying more clearly or reiterating group rules, setting limits, and promoting a positive interchange among members so they will want to continue. Additionally, group trust and cohesion are slowly being formed, members are learning and displaying appropriate ways of behaving socially (including active listening and responding), and they are deciding how they fit into the group. Group leaders will assist the members to express feelings and thoughts, help the members take ownership of the group (in terms of its direction and outcome), and will discuss general group guidelines and norms (Corey, 2015).

The transition stage often follows the initial stage of group. In this stage, anxiety, defense mechanisms, and resistance among group members may take place. Members will learn how to manage conflict more effectively and begin to practice this management in the group as it occurs. Members may also begin to question the trust and safety of the group and decide the level of emotional involvement that they wish to invest in the group. Group members, with the assistance of the group leader, may also begin to learn the manner to recognize issues of transference, express themselves more directly, and begin to identify and work through defense and resistance mechanisms. (Corey, 2015). Jacobs et al. (2016) also describe this stage as part of the middle or working stage.

The closing stage of a group involves terminating the group. As mentioned, this may be best suited for closed groups; however, open groups will also experience

termination/ending of a group as members leave the group in a planned way. In this stage, members recap their experiences, what they have learned, what changes they have experienced personally, and the ways that they plan to continue to use those changes once the group has ended. In this stage, members are also assisted in making a planned goodbye to the group and the experience (Jacobs et al., 2016).

In terms of facilitation of groups, or group leadership, it is again important to note that there are general characteristics that leaders will need to be most effective. Consideration for more specialized groups will require additional characteristics or skills. In general, groups are typically facilitated by one or two leaders. This is determined based on the type of group and what purpose/needs have been identified when forming the group. For example, psychoeducational groups usually can sufficiently be led by one person. Counseling and psychotherapy groups and any groups that focus on content and process are likely best served by two group counselors. Kivilighan et al. (2012) determined that group members that engaged in groups led by two counselors ("co-led" or "co-facilitated") found "greater benefit from treatment than those group members in individually led groups" (p. 1). This suggests that co-facilitated groups have more benefit or advantages than groups led by one person. Other researchers support co-led groups due to the many benefits they provide. Bridbord and DeLucia-Waack (2011) assert that "co-leaders may enhance and balance group process and interaction, helping group members to benefit from multiple perspectives and experience support and empathy from one while being challenged by the other" (p. 203). Yalom (1995) further suggests that when co-therapy is utilized in groups, the counselors complement and

support one another, their observations are better, and together they can implement more strategies and viewpoints. He also supports co-leadership for beginning counselors in particular to help reduce anxiety and increase their objectivity. Co-counselors also demonstrate modeling for group members on multiple levels, as well as support for their co-leader.

Regarding group leadership characteristics, counselors want to possess several characteristics. These characteristics include: empathy, genuine caring, openness, flexibility, warmth, trustworthiness, patience, confidence to lead, ability to be in tune with others, awareness of the group as a whole, ability to work well with a co-leader, and good psychological health overall. Some researchers suggest that group counselors seek or should already have sought personal counseling to help minimize any difficulties that may arise from the multiple issues and dynamics that group work can generate (Corey, 2015; Jacobs et al., 2016; Yalom, 1995). Being a multi-culturally informed group counselor is especially important. Having a good self-awareness of one's own culture, values, and biases, as well as how each group member views their world from a cultural perspective are important. Additionally, understanding how diversity can enhance group content and process, as well as understanding how oppression, stereotypes, and discrimination will affect a person and contribute to their world view is very important (Corey, 2015). Ignoring or denying multicultural influences on group work creates a disservice for the group members individually and collectively, can increase harm, and decreases the effectiveness of group counseling and group dynamics.

With respect to co-leadership, Bridbord and DeLucia-Waack (2011) determined characteristics of co-therapists that produced higher levels of co-leader relationship satisfaction, which makes for increased likelihood that group members will have a better experience. They discovered that co-leaders that demonstrate a level of respect for one another and agree on theoretical and leadership approaches are more satisfied with their roles as co-leaders. Additionally, co-leaders that agree on the amount of self-disclosure and level of direction in groups felt more satisfied and effective in groups. Finally, preparing for group, frequent consultation with one another outside of group, and/or regular supervision also accounted for effective co-leadership.

Clinical Staff Impact on Therapeutic Milieu

Staff relationships' influence on the therapeutic milieu can be great, in both positive and negative ways. According to Garman et al. (2002), emotional exhaustion, depersonalization, and having a negative view of personal accomplishment lead to counselor burnout. When counselor burnout or other conflicts within the immediate clinical team occur, these negatively impact client care, as well as the cohesion and morale of the team. This may lead to increased sickness and staff turnover, absenteeism, and vacancies in counselor roles. As counselors, we owe it to those we serve to work effectively as a team.

Thorndycraft and McCabe (2008) proposed a model to improve staff relationships to change the trajectory from a negative to a positive influence towards the therapeutic milieu and within the clinical team (or to prevent negative impacts on patient milieu). The model includes providing a safe space where the clinical team may have the

opportunity to share, in a non-judgmental environment, how the work impacts their personal, physical, and psychological health and their relationships with colleagues. Fostering the gain of mutual support, knowledge, and insight from others in a trusting, open, and honest environment where confidentiality is paramount. Providing opportunities for the development of multidisciplinary communication structures within the team leads to greater understanding and respect for the role of others.

Thorndycraft and McCabe (2008) further suggested the development, through group process, of a consistent and cohesive team approach, whereby clear procedures and boundaries when working with patients, are agreed upon and adhered to by the whole team. Additionally, sharing concerns and uncertainties regarding work with patients and exploring strategies when difficulties arise support team cohesion. Furthermore, allowing counselors to step out of their role and share their differences of professional opinions, style, and therapeutic orientation, without judgment, allows for healthy dialogue and confidence in professional capacity.

Kirk et al. (2001) proposed ways to "strengthen interpersonal relationships between supervisors and subordinates and to develop a positive work environment" (p. 5) by utilizing counseling approaches. They proposed eight approaches; however, three will be briefly discussed here: person-centered, gestalt, and reality therapy.

The person-centered approach focuses on empathy and acceptance, assists in recognizing blocks to growth, and is deemed useful for co-worker conflict, cultural and diversity training, and changes in careers or positions and responsibilities. Gestalt approaches focus on how earlier events and experiences affect current problems and

stressors. This approach helps any members of the clinical team to examine unfinished business and is useful for behavior problems and awareness trainings. Reality therapy concentrates on current behavior and the effect it has on the here and now. It also emphasizes change as a choice that must be made by a team member or members. This approach works for disciplinary actions, behavior problems, co-worker conflicts, or performance problems.

Benefits of Traditional Group Counseling

The benefits of traditional group counseling are many and extend far beyond cost effectiveness. Group counseling is offered in a variety of settings and in all levels of care for mental health and substance abuse counseling. "Not only is group therapy an evidence-based effective treatment, but it is also more-cost effective than individual therapy and, therefore, more likely to be accessible to the ever-increasing numbers of individuals in need of mental health treatment" (Puskar et al., 2012, p. 225). Several studies found that homogeneous groups found multiple benefits in traditional group therapy. In a study of individuals receiving group counseling for grief issues, Vlasto (2010) identified the following benefits of their experiences in traditional group work: social contact, increased social skills, support, an environment of honest sharing, and normalization of feelings. In addition, group members described that "being witnessed and witnessing others at various stages…was seen as conveying 'hope'" (p. 62). Another study found traditional group counseling to provide many benefits to female survivors of childhood sexual abuse. Gorey et al. (2001) discovered that these female survivors, after completion of group therapy, had significantly decreased feelings of guilt, shame, and

self-blame. Additionally, the group members felt less isolated, more hopeful, and more empowered about their future. Furthermore, of these group members, six months after the group terminated, 90% maintained their sense of hopefulness.

Benefits of Art/Expressive Therapy in Group Counseling

Art and other expressive therapies (such as reflective writing, music, and drama) also provide benefits to group members, some of which are similar to the benefits of traditional group therapy, but which offer a unique set of benefits that are not necessarily possible with traditional group counseling alone. Art and expressive approaches can help group members tangibly externalize the problems that they are experiencing, which can open new possibilities for change (Hill, 2011). Drapeau and Kronish (2007) assert that art helps group members "reveal their feelings and often [leads] them to discussions that would not have occurred" otherwise, and that the "process of group therapy enabled patients to disclose very intimate and worrisome issues" (p. 78). Additionally, creative art therapy groups help participants decrease isolation, increase personal connectedness, self-esteem, and ego strength, feel more secure in feeling expression, and improve their quality of life.

Grebin and Vogel (2006/2007) offer multiple expressive therapy approaches to group counseling, including art, bibliotherapy, creative writing, closing rituals and ceremonies, films and movies, and music. They suggest that "visual arts allow individuals to work through and release the pain they may be experiencing" (p. 66). Storytelling and bibliotherapy allow for normalization of feelings and experiences, as well as validation. Music approaches in groups can provide "solace and hope for those desiring to work

through their loss with meaning. In a group setting, music can be a catalyst for empathy, bonding, and emotional expression" (p. 68). Similarly, Zare et al. (2007) indicate that when patients attended a creative based therapy group prior to traditional group psychotherapy, their readiness and responsiveness were more emotionally expressive, and often, the rich processing that occurred in these expressive groups was expanded upon in the traditional psychotherapy group. It was also found that expressive writing may be a useful supplement to existing interventions for depression (Krpan et al., 2013).

There have been two extensive literature reviews conducted on art or expressive based research. The purpose of these reviews was to understand not only the benefits of art and expressive therapies in group and individual therapy settings, but also to provide support for art and expressive therapies as an evidenced-based practice. The first review focused on art therapy literature (Reynolds et al., 2000) before 1999. The second literature review (Slayton et al., 2007) focused on outcome measures of art therapy's effect on various populations and settings from 2000-2007. Insights into the benefits of art therapy were gleaned as a result of these reviews. Sixteen of those insights will be summarized (these were highlighted because they focused on group art therapy sessions). As a result of art therapy interventions, the following benefits occurred, as cited by Slayton et al. (2007): positive experience and having a safe space to move through grief (Ferszt et al., 2004); increased coping in response to feelings (Gersch & Sao Joao Goncalves, 2006); art was viewed as more advantageous over talking alone (Nowicka-Sauer, 2007); increased frustration tolerance and decreased cognitive distortions (Smeijsters & Cleven, 2006); reduced distress, as evidenced by significantly lowered

scores on the Positive Symptom Distress Index (Franks & Whitaker, 2007); improved behavior and mood functioning (Gussak, 2004); significant reductions in anxiety, post-traumatic stress disorder (PTSD), and dissociation scales (Pifalo, 2002); significant reductions in trauma symptoms (Pifalo, 2006); increased positive self-image (Ponteri, 2001); positive change six months after intervention (Wallace-DiGarbo & Hill, 2006); increased self-esteem ratings (Hartz & Thick, 2005); decreased burnout (Italia et al., 2008); decreased depression (Gussak, 2006); decreased trauma symptoms and improved behavior (Lyshak-Stelzer et al., 2007); mood improvement based on scales (Puig et al., 2006); and increased mental alertness, social interactions, and physical engagement (Rusted et al., 2006). In addition, preliminary data from an agency indicates that "participants using art therapy make less phone calls to medical and mental health providers; require fewer referrals to medical specialists; have a decreased number of somatic symptoms and complaints; and reduce their utilization of medical and mental health services" (Dale, 2008, as cited by Slayton et al., 2007, p. 116).

In a study about the efficacy of art therapy in the treatment of personality disorders (Haeyen et al., 2015), patients experienced art therapy as "a more direct way to access emotions, which they attributed to the appeal of art materials and art making to bodily sensations and emotional responses…[Art therapy offered] a specific pathway to more emotional awareness and constructive emotional regulation" (p. 1). Other similar studies on art therapy in the treatment of borderline personality disorder (in conjunction with more traditional methods of counseling, i.e., dialectal behavioral therapy), support these benefits (Eastwood, 2012; Huckvale & Learmonth, 2009).

Therapeutic Milieu

A therapeutic milieu is paramount to the success of a partial hospitalization program. Milieu and therapeutic milieu have been defined by several researchers in the literature and will be introduced here. A milieu is defined as any environment or culture in which a person lives or is a part (Gunderson, 1978; Houvenagle, 2015). Further, a therapeutic milieu, as defined by Gunderson (1978), is when the "milieu itself is recognized as an active therapeutic agency to promote and facilitate 'positive' changes in specified directions. It cannot be prescribed…[but rather] developed within a system when a need is felt and the value…is recognized" (p. 332). DiBella, et al. (1982), described a therapeutic milieu as a group treatment environment that is supervised and designed by professionals and "provides a model of the everyday world of reality and maximized opportunities for patients to benefit from their social and physical surroundings" (p. 66).

Based on the definition alone, the success of the therapeutic milieu is dependent on many factors, including staff makeup and buy-in to the concepts of therapeutic milieus (Mahoney et al., 2009), the client population of a respective milieu (Green, 2018; Gunderson, 1978; Houvengale, 2015), and managed care (Green, 2018; Houvenagle, 2015; Mahoney et al., 2009). There are also several approaches to designing and implementing effective therapeutic milieus, and four will be described in more detail: (a) Gunderson's therapeutic processes (1978), (b) Yalom's therapeutic factors (1995), (c) Marten's factors of psychological holding (n.d.), and (d) optimal healing environments (Jonas & Chez, 2004). Additional examples and suggestions for creating a supportive

group environment in a PHP and IOP setting are explored later in this work. The examples and suggestions incorporate the four approaches previously mentioned.

Gunderson's Therapeutic Processes and Application in PHP

"The therapeutic power (of milieu treatment) can be equal to or even greater than that obtainable with drugs[/psychiatric medications] for some patients" (Gunderson, 1978, p. 327). While there is great truth to this statement, it is not without limitations, in that "no single type of therapeutic activity is ideal for all patients or at all times for any given patient…and no single milieu can optimally provide all types of therapeutic functions…[The goal] is to develop a maximally flexible milieu which can provide all therapeutic functions reasonably well" (p. 333).

Due to a lack of research on what processes determine whether a milieu is therapeutic or not, Gunderson (1978) developed five therapeutic processes to guide programs to create a therapeutic milieu. The site studied aimed to embody the five therapeutic processes that are outlined here:

1. Containment
2. Support
3. Structure
4. Involvement
5. Validation

The containment variable of the therapeutic process (TP) is described as sustaining the physical well-being of patients. Dirr (2007) also suggests that containment is both for the physical and the emotional well-being of patients: that is the physical

containment from external threats and emotional containment for internal threats (destructive, painful, and overwhelming feelings). Examples of the application of containment are providing shelter within a hospital setting that has security and safety measures in place, providing free lunch and drinks each day, and staff being trained to de-escalate physically dangerous situations.

The function of the support variable in the TP is to increase security and comfort of patients, increase self-esteem, and decrease anxiety and distress. How this is demonstrated in a PHP setting is through written and verbal affirmations, appropriate personal disclosure of staff or staff reactions to what is occurring during a group or in the milieu, open-door policy (within reason) that states that patients can stop by a staff member's office during the treatment day to ask questions or even after discharge to update the staff member on how they are progressing since leaving PHP or IOP. When staff seek opportunities to have patients recall times of success, this could be viewed as support of a patient's previous abilities and possible future success, as well as a way to "make patients feel more lovable and be more charitable" (Gunderson, 1978, p. 329).

Structure within the milieu promotes a safe attachment to the environment. Beyond the milieu, structure also provides opportunities for ongoing change in the patient's symptoms and socially maladaptive patterns. This is demonstrated in the PHP in many ways. The setting itself (the group/treatment room) is well established and does not change day to day. The PHP is predictable in that it has a set schedule each day, it begins and ends at the same time each day, and the number of days that patients attend is the same each week. For those in IOP settings, there is an expectation that they will

attend the same three days each week (at times, allowing for some flexibility based on extenuating circumstances).

The fourth process of the TP is involvement. This variable causes patients to attend to and interact with their social environment by attending and participating in groups, asking for unmet needs through assertive communication, and working on modifying interpersonal patterns that create difficulty. In PHP settings, implementing community meetings and having patients help make decisions for and about the milieu is very important. A community meeting is a time and place when patients can bring up questions and concerns about the milieu setting, participate in the decision making, and work on unfinished business as it relates to the milieu. Involvement strengthens the ego, decreases passivity, and increases the sense of belonging.

The last process of the TP is validation. Validation is affirming the patient's individuality. In PHP settings, this is partly accomplished through individualized treatment planning that is done in collaboration with the patient and counselor. Other examples of supporting individuality are encouraging self-care and alone time in and outside the milieu, conducting weekly individual therapy sessions within the PHP day, and providing opportunities to fail and tolerate loss.

Therapeutic Factors in Group Counseling

Yalom (1995) proposed a set of therapeutic factors that take place as a result of the group therapy experience, which in turn benefit the group members not only during the group process but outside the group setting as well. The therapeutic factors include altruism, catharsis, corrective recapitulation of the primary family group, existential

factors, group cohesiveness, imitative behavior, imparting information, instillation of hope, interpersonal learning, socialization techniques, and universality. These factors do not occur independently and often are interconnected with one another. Each factor is briefly described from the author's perceptions as a long-time group counselor in a PHP, as well as with any additional information presented from Yalom (1995).

The instillation of hope is the process by which group members instill in one another that there is hope despite circumstances that are occurring in their lives. In PHPs, the groups are open, meaning each member will be admitted and discharged at varying intervals. This is different from a closed group in which group members enter and leave the program at the same time. Instillation of hope is reinforced frequently in a PHP because of the open-ended group. Members are at different stages, and those that are closer to discharging from the program are examples that there is hope. This is important for incoming members of the group to witness. Group members often feel more hopeful as a result of seeing peers feeling better since admission to the program.

Universality creates a feeling for group members that they are not alone in what they experience. Other people have similar experiences. In my experience as a group counselor, group members often report feeling less alone. Yalom (1995) further states that "patients report feeling more in touch with the world and describe the process as a 'welcome to the human race' experience" (p. 6). Group members often feel listened to, validated, and no longer suffer from terminal uniqueness.

The main approach to imparting information to group members is through psychoeducation groups. Briefly, psychoeducation groups are used to give members an

opportunity to understand symptoms, ways to manage them more effectively, increase knowledge of coping skills, and so on. Yalom (1995) believes this to be a therapeutic factor because it helps to ease the level of uncertainty felt by group members, and once information is imparted to them, they can more effectively experience the other therapeutic factors as part of the group phenomena.

The corrective recapitulation of the primary family group relates to past family-of-origin relationships that often become re-enacted during the group therapy experience (Yalom, 1995). The goal is to help group members find new ways of interacting with others during a group, which could then be translated to outside the group setting and may result in more positive relationships both in and out of group.

Socialization techniques and imitative behavior (Yalom, 1995) often occur together in a group. Depending on the make-up of the group, members sometimes lack an understanding as to how to interact appropriately with others (both in and outside of the group). Role playing social cues and social experiences occur in the group setting. Imitating appropriate social techniques that are learned from group leaders and group peers is a good opportunity for members to practice in their day-to-day lives. Feedback during group therapy between members is strongly encouraged and may also be given from the group leaders. Group members that have been in the program longer may be more comfortable at providing and receiving feedback to or from fellow peers, but newer members may experience increased anxiety or defensiveness. Group therapy can be a place where defenses decrease over time and members are more comfortable speaking freely and honestly in a safe environment.

Interpersonal learning is another benefit and therapeutic factor that occurs in group therapy. According to Yalom (1995), the goal of interpersonal learning in group psychotherapy is to help the member develop "distortion-free, gratifying interpersonal relationships," increase self-awareness in relation to others through active engagement and feedback with peers and group leaders, have an increased sense of emotional responsibility, and gradually increase their motivation to change as a result of the group therapy experience (pp. 42-43).

Group cohesiveness is another benefit of group psychotherapy. Yalom (1995) defines this as "the condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by other members" (p. 48). Once this begins to take form, groups begin to transform (i.e., from one stage of group to another) and healing can become transcendent. Although art and expressive therapies are discussed later, group cohesiveness can be facilitated in these creative groups. By asking members to create a group art piece, create art for each other, or to respond to a theme set forth by the group counselor using art, music, and/or writing and discuss the responses via a group process, the level of cohesiveness appears to increase. Cohesiveness, or lack of, in a group is critical to the development of the group and the members' experience.

Martens (n.d.) has identified twelve factors of psychological holding that contribute to the formulation and success of the therapeutic milieu. These are factors modeled by the clinical team in the PHP/IOP in the current study and hopefully adopted by the patients in PHP/IOP over time. Below are the twelve factors, some of which

overlap from the two previous processes and factors of Gunderson (1978) and Yalom (1995):

1. Adapting to the patient need
2. Being more than doing
3. Caring and Supportive
4. Constant and Reliable
5. Emotionally Available
6. Empathic
7. Non-judgmental
8. Practical
9. Responding to the patient's affect rather than their behavior
10. Staff will avoid acting out personal frustrations
11. Timely/Punctual
12. Understanding (Martens, n.d.).

An alternative perspective to therapeutic milieus is the concept of optimal health environments (Jonas & Chez, 2004). It is suggested that due to limited stays, increased incidents of managed care, primary focus on pharmacology and symptom management, and the "lack of an organizing framework for milieu therapy…to support an evidence-based approach for the therapeutic milieu concept", that this concept needs reexamining (Mahoney et al., 2009, p. 424). Optimal healing environments involve seven features (Jonas & Chez, 2004): (a) building healing spaces, (b) creating healing places, (c) developing awareness and intentions, (d) experiencing personal wholeness, (e) cultivating

healing relationships, (f) practicing healthy lifestyles, and (g) applying collaborative medicine.

Building healing spaces involves planning the physical environment to include nature, light, art, smells, music, and so on that are conducive to the healing space for patients. Healing places focuses on "leadership, mission, culture, teamwork, technology, evaluation, and service that are in alignment with intentional healing" (Mahoney et al., 2009, p. 425). Developing awareness and intention expects that the clinician will function as a healer, will take a biological-psychological-social-spiritual approach to understanding a person's state of health, and will exhibit a belief in the person's ability to heal or recover. Experiencing personal wholeness is providing holistic care (body, mind, and soul). Cultivating healing relationships is to nurture care, compassion, communication, empathy, and support. Practicing healthy lifestyles is to support and encourage exercise, finding balance, following healthy diet plans, and relaxation. Lastly, the applying collaborative medicine approach is to combine alternative, conventional, and traditional practices of care with strong collaborative interdisciplinary teams and a practice of patient-centered care (Jonas & Chez, 2004).

Suggestions for Creating a Supportive Group Environment in a PHP Setting: Theory to Practice

The therapeutic factors of Yalom (1995), Gunderson's therapeutic processes (1978), and the work of Martens (n.d.), all complement the therapeutic milieu well, all emphasizing the here and now, emotional and physical safety, and relationship building between staff and group members and each other (Farkas & Cameron, 1998).

Suggestions by Long and Sauselen (2013) for counselors to apply these factors are described below.

The clinical team's expectation is for participants to function at the maximum of their ability. In order for this to happen, counselors will have to intentionally engage quieter members, and set limits to contain talkative members. Members are encouraged to achieve catharsis. However, if a cathartic experiences becomes overwhelming, counselor should step in to protect the group member and provide supportive containment. Members may be involved to engage through discussion or problem-solving mode. Counselors may prompt responses from other members in the form of support, advice, questions or personal reactions and acknowledge responses as helpful contributions to the group. Counselors are encouraged to highlight similarities in patients' problems and responses, which is done at by focusing on: (a) problem area, (b) response to different problems, and (c) the process of coping (Long & Sauselen, 2013; Yalom, 1995).

Counselors can provide helpful input about the types of human problems experienced by clients, productive and unproductive ways of coping with problems, and the process of healing and recovery. It is important for the counselors to avoid teaching in a didactic manner but instead elicit client stories and experiences to highlight problems and themes. Counselors must model an accepting stance toward all patients and help clients have hope that crises will pass, and that existing problems can be managed, and recovery is possible (Yalom, 1995). It is recommended that counselors focus on interpersonal style only if a client is stable enough to use the feedback or if a client being

disruptive (Yalom, 1995). Group clinicians will also redirect requests for answers back to the group or the patient in order to promote discussions of responsibility and control as they emerge around problem areas (i.e., role in treatment, medication compliance, or responsibilities at home, work, school, etc.). Participants will be encouraged to focus their discussion of feelings on current problem areas as opposed to historical problems, as well as a discussion of existential issues (i.e., isolation, responsibility, meaning, death, etc.) as they emerge. Group counselors will also encourage interactions outside the group to further discuss common issues (within the treatment day, i.e., during lunch or other built in break time) (Long & Sauselen, 2013).

According to Vatne and Hoem (2008), when feelings and experiences are supported as important and valid, people may feel more confident in knowing they are experts on their own lives. The counselors' ability to understand the clients subjective reality is necessary to attain a therapeutic change. Counselors need to examine their own contributions (behaviors and responses) to situations that arise in the therapeutic milieu. Acknowledging patients involves a shift from authoritarian messages to using wondering, reflective questions based on emotional listening (Vatne and Home, 2008). Self-disclosure, used judiciously, can help professionals to develop closer relationships with patients.

To further demonstrate how the therapeutic processes, therapeutic factors, and elements of psychological holding are implemented in a PHP, the following are site-specific examples that can also be adopted by other programs (Long & Sauselen, 2013):

- Aesthetically pleasing

- Affirmation development
- All staff is educated and reinforced on therapeutic milieu
- Balance of formal/informal roles between clinical team and patients
- Breaks
- CD player/radio
- Challenges just before or at the patient's boundary
- Clinical team strives to link group content back to treatment goals through continuous communication daily and weekly
- Community meeting—patients can express concerns
- Creative arts chats
- Displaying of group-created artwork
- Group room established—does not change
- Kleenex
- Lunch provided
- Maintain flexible, yet professional boundaries
- Mutual development of treatment plan
- Orient patients to and maintain daily group schedule
- Predictability—i.e., same staff doing same groups
- Refreshments available daily
- Roles of staff are communicated
- Settling differences among staff
- Staff participation in art and expressive therapies

- Team meets daily to discuss program issues
- Team presents a united front to avoid staff splitting
- Timeliness
- Transitional objects
- Weekly meetings between clinical team member (care manager) and patient to discuss treatment planning, progress, ground rules for group, confidentiality, attendance, and open communication with care manager

Description of a Partial Hospitalization Program

The medical reasons for admission to a PHP are (a) to increase access to a therapeutic milieu for people with mental health issues that require a higher level of care beyond outpatient counseling, but their symptoms do not warrant an inpatient hospitalization; (b) hospitalization was possible without the intervention of a PHP; c) and/or it was a step down for those recently discharging from the inpatient mental health unit within the hospital. When patients are referred to PHP or IOP from an inpatient unit, within the same hospital setting, the potential benefit "can facilitate transition of care and may reduce dropout rates" (Khawaja & Westermeyer, 2010, p. 28).

Consistent with the literature, participants in a PHP meet specific criteria for admission to the program, including medical necessity (which is required for most insurance companies that provide payment for services received, but most importantly, ensures that each member of the group is clinically appropriate for this level of care). Medical necessity, based on a definition provided by CMS (2014), is as follows:

> Patients admitted to a PHP do not require 24 hour per day supervision as provided in an inpatient setting, must have an adequate support system to sustain/maintain themselves outside the PHP and must not be an imminent danger to themselves or others. Patients admitted to a PHP generally have an acute onset or decompensation of a covered Axis I mental disorder, as defined by the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or listed in Chapter 5, of the version of the International Classification of Diseases (ICD) applicable to the service date, which severely interferes with multiple areas of daily life. The degree of impairment will be severe enough to require a multidisciplinary intensive, structured program, but not so limiting that patients cannot benefit from participating in an active treatment program. It is the need, as certified by the treating physician, for the intensive, structured combination of services provided by the program that constitute active treatment, that are necessary to appropriately treat the patient's presenting psychiatric condition (p. 8).

Intensive outpatient programs (IOP) may serve as a step down from inpatient care or PHP, or for outpatients needing more intensive care than office visits. Patients typically attend three to four days per week, at a maximum of eleven hours per week.

Participants are required to meet criteria for a mood disorder from the *Diagnostic and Statistical Manual for Mental and Emotional Disorders, Fifth Edition* (DSM-V), which is set forth by the American Psychological Association (2013). While there are many possible diagnoses (depending on the type of PHP), the most common

diagnoses at the site for this study are major depression with moderate to severe symptoms, anxiety disorders, post-traumatic stress disorder, and bipolar illness. Other participants presented with co-occurring diagnoses such as a personality disorder, substance abuse/dependence, or a medical condition. The symptoms experienced are beginning to impact their ability to function on a daily basis and are generally acute in nature. Symptoms may include difficulty attending work or school, decreased hygiene, decreased/increased appetite, sleep difficulties, or struggling to leave the house or drive.

Participants must also exhibit a major impairment in one or more areas, such as work or school, family relations, judgment, thinking, or mood. Additionally, participants must be able to cognitively and emotionally tolerate the therapeutic milieu, have medical clearance, and be independent in their behaviors (i.e., not require consistent supervision and monitoring, which is typically required in an inpatient or residential setting).

Exclusionary criteria for admission to PHP and IOP that serve adult populations is also considered. The following are not good candidates for adult PHP or IOPs that focus on the treatment of symptoms related to a mental health diagnosis that is primary: (a) anyone under the age of 18; (b) someone that is actively suicidal and requiring very close, intensive staff supervision or restraint; (c) anyone that is severely disorganized and is deemed dangerous to self or others; (d) an individual that is severely impulsive in destructive or life threatening ways; (e) a person that presents with an uncontrollable

alcohol or substance abuse problem; and (f) those with gross medical or neurological impairments that interfere with full participation in the program.

The combined PHP and IOP studied is in a rural Midwestern community and in the building of a general hospital. The program is structured so that the milieu will have at least three, but no more than ten members attending the program at one time, which is considered a best practice as defined by CMS standards (Meikel, 2019). PHPs are open-ended, meaning members are admitted at any point during the group program and that members are often at varying stages of recovery from their presenting concerns/symptoms. Group members are not required to have a referral; however, many of them were referred by their psychiatrist, ongoing outpatient counselor, primary care physician, or following discharge from inpatient psychiatric care and so on. Once the referral was made (or they referred themselves), then the potential PHP group member is scheduled for an intake by one of the clinical team members to see if the member meets criteria for admission to the program. Additional factors for admission are a commitment to participate in treatment, a willingness to abstain from or work towards decreasing self-destructive behaviors (which include, but are not limited to, drug and alcohol use, cutting, or other self-harming behaviors), and commitment to the treatment schedule. Group members may be excluded if they are hostile or pose a physical or emotional harm to other group members. If a referral is floridly psychotic or cannot tolerate the emotional intensity of the program and being admitted to the program would further destabilize them, then these may be additional exclusionary criteria for admission.

Khawaja, et al. (2008) suggest using the mnemonic "MOTIVATES" to identify good candidates for admission to a PHP:

- **M**otivated
- **O**rganized
- **T**olerates a milieu or group setting
- **I**nterested in recovery
- **V**erbal **A**bility
- **T**reatment adherent
- **E**xperience
- **S**afe

While this is a helpful guide, formal assessments and examining issues case by case is of the utmost importance. Once the decision has been made for admission, and the client is agreeable, they are ready to begin the program.

The Center for Medicaid and Medicare Services guidelines for PHPs are typically viewed as the so-called gold standard in how programs are structured. The following are current requirements set forth by CMS for PHP: The patient is to be seen by a physician within twenty-four to forty-eight hours of admission to PHP or IOP, to determine medical necessity. After the initial physician consult, PHP patients are to be seen weekly, and IOP patients are to be seen as needed, at least once per month after the consult appointment. Treatment plans are to be developed within seven days of admission and updated weekly thereafter, with physician, patient, and treatment team member signatures. Physician appointments are to be scheduled outside of a group or

individual session time. There should be one-hour individual counseling sessions by the assigned team therapist at least one time per week for those in a PHP level of care and at least one hour per month individually and as needed for those in the IOP level of care. Those admitted to PHP are required to be scheduled for twenty hours of group per week and groups must be multi-modal (i.e., cannot offer strictly traditional group therapy but must also include things like expressive therapy or psychoeducational groups). Any less than three billed services per day is not considered PHP and will be denied payment by CMS. IOPs may be billed a maximum of eleven hours per week. The census for PHP is a minimum of three and maximum of ten participants to protect the integrity of the therapeutic milieu (this involves all aspects of PHPs, including psychoeducational groups).

PHPs are typically structured so that group members attend four groups per day, five days per week. An average length of stay in the site of this study is seventeen treatment days; however, in some cases the stay was shorter or longer depending on a variety of factors, including level of symptoms, progress towards treatment goals, or costs that the patient may incur, just to name a few. PHP is a level of care that is covered by most insurance companies, including Medicare and Medicaid.

Description of Studied PHP/IOP Site

The site studied is a combined PHP/IOP that began in December 1991 and is currently managed by a licensed professional clinical counselor with supervision endorsement (LPCC-S). Other clinical staff includes a full-time licensed professional counselor (LPC), a full-time art therapist/LPC, and another full-time LPCC-S. The

program is also under the medical direction of a board-certified psychiatrist that meets with patients for medication management and to deem medical necessity. The combined program serves the adult population, those aged eighteen and older.

Prior to admission to PHP or IOP, all referrals to the program must complete an intake assessment. The intake appointment is free of charge and lasts approximately one hour. It primarily focuses on current symptoms and stressors, suicidal or homicidal ideation, current medications and previous medication trials, and current and previous psychiatric treatment, in order to determine the best level of care, along with the appropriateness for the therapeutic milieu. The program is also explained to the person and any questions or concerns are answered. If the person does not meet criteria, they are appropriately referred to or directly linked with alternative providers. If the person does meet criteria, they will start the program as soon as possible, which sometimes may be the same day or the next scheduled day of programming. Once admitted, they are given a written outline of expectations and how to get the most out of being in a therapy group, such as PHP or IOP (Appendix B).

Those enrolled in a PHP level of care are seen weekly by the psychiatrist, and those enrolled in a IOP level of care are seen once initially and then as needed, and the clinical team meets with the psychiatrist weekly for case reviews of all patients currently attending either level of care in the combined program. Outside of the formal case reviews with the doctor, the clinical team meets daily for 30 minutes before the treatment day begins and as needed throughout the day. Additionally, all PHP patients receive one-hour individual counseling sessions each week as part of the treatment day,

and IOP patients are met with weekly for 30 to 45 minutes or as needed, depending on the needs of the patient (IOP patients are required to have at least one individual session per month, totaling 60 minutes). All patients that were admitted to the program were required to have a treatment plan, developed in collaboration with the treatment provider and the patient. Each service that the patient receives was also documented in the electronic medical record.

Each treatment day of the studied site began at 8:30 a.m. and started with a community meeting. This 20 to 30-minute meeting is designed to welcome the patients each day to the program, to make any program announcements, to note anyone that has any schedule changes for the day, to remind them of what will take place for that particular day, to introduce any new members to the group, and to check in briefly about how the previous evening went for each group member. The purpose of this meeting is to begin to establish a sense of community within the group, to have a general sense of how each person is doing, and to see if they have met goals from the previous night (i.e., checking on how functional they are when they return home in the evenings and on weekends). The community meeting can often set the tone for the therapeutic milieu, as this is the time to discuss concerns about the program, and group members will have input on those decisions. The community meeting is an example of involvement from the therapeutic processes of Gunderson (1978). Involvement encourages interaction and attending to the social environment.

The first treatment group of the day begins at 9:00 a.m. The actual group content is different depending on the day of the week. The structure of the first group

of the treatment day has changed over time. As mentioned in the literature review section, creative approaches, including psychodrama, art, expressive, and reflective writing, all seem to increase emotional expressiveness, allow for group members to see themselves as the experts of their own lives, promote increased personal sharing, and increases connectedness between group members (Drapeau & Kronish, 2007; Hill, 2011; Zare et al., 2007). While this has not formally been studied in the PHP described here, the clinical staff has noticed this phenomena occurring as well—that when patients attended a creative based therapy group prior to traditional group psychotherapy, their readiness and responsiveness was more emotionally expressive, and often the rich processing that occurred in these expressive groups was expanded upon in the traditional psychotherapy group. For this reason, the structure currently is that the patients will have one of the following groups at the 9:00 time slot, three of the five days each week: art therapy, reflective writing, or expressive therapy (art, music, writing, drama, or any combination of the expressive therapies). Most of these groups are led by the art therapist on staff (this position in the past has been held by music therapists as well). Following this group, there is a one-hour break, which gives an opportunity for clinical staff to meet with group members for individual counseling or for the psychiatrist to meet with patients for medication management and/or consultation. The hour break also allows for continued milieu development, allowing group members to get to know one another in a more informal way.

The second group of the day is the traditional psychotherapy group. The focus of this group is co-led by the program manager (LPCC-S) and a licensed professional

counselor. This group allows patients to have an opportunity to discuss whatever they might be struggling with that day, and they are strongly encouraged to focus on issues related to their treatment plan. If it is someone's first day in this group, they are asked to share what brought them into the program. Also, if someone is leaving the program that day, they are asked to share what their experiences have been like in the program, the progress they have made, and what their plan is after leaving the program. Aside from these situations, patients are free to share what is on their minds, process it during group, and can request feedback from others in the group, as they feel necessary. After this group, the members have a lunch break. They are given a ticket worth up to $5.00 that can be used in the hospital cafeteria. This is an opportunity to promote increased cohesiveness, reduced anxiety over time, and increased support between group members.

The third group of the day is typically a psychoeducation group. A psychoeducation group can be described as a group that offers a set of skills to be learned, practiced, or refined, and these are often communicated through some sort of structured lecture or discussion led by the group counselor; alternatively, a worksheet or activity is utilized. Examples of psychoeducation groups in this PHP are assertiveness training, emotion management, goal planning, personal recovery (topics such as diagnoses, medications, for example, are discussed, as well as relapse prevention planning, in which participants are encouraged to create a relapse prevention plan to utilize post discharge for recovery maintenance), self-esteem, stress management, and special topics. For special topics, the topics change weekly for this

group and are often based on the needs of the milieu at the time. Examples of special topics may include, but are not limited to understanding addiction, boundaries, grief, healthy relationships, or other topics by request or design. Again, the group is dependent on the day of the week and is led by any of the four staff members.

The final group of the day on Tuesdays, Wednesdays, and Thursdays is one of the psychoeducation groups listed above. A creative arts group is at the end of the day on Mondays and Fridays. This creative group is different from the art or expressive groups that were described earlier. The creative arts group provides an opportunity for participants to have a more relaxed experience, as it promotes spontaneous conversation, helps group members to identify leisure outlets, and increases their ability to focus and concentrate, their personal decision making, and their follow-through. This group is staffed by the art therapist/counselor and is held in an art room that is separate from the PHP group room. The setting can also help patients transition from the emotions/issues of the day to a more relaxed and hopefully less stressful space. Group members are asked to choose an art project of their choice to work on for the hour, and they will work on this project from its beginning to end before choosing another project. These guidelines are in place to assist in those opportunities listed above.

At the end of each day, the group members are asked to identify one or more personal strength or accomplishment they had for the day, as well as one goal they would like to accomplish for the evening. The evening goal is encouraged to match

with something related to their treatment plan goals to support ongoing progress in a tangible way outside the milieu.

There is also a significant ritual that occurs within the structure of the program that, based on previous experiences of patients and clinical staff, has become very meaningful and sometimes emotional. For some patients, saying goodbye has been difficult or does not occur formally in their lives. The program strongly encourages patients to attend the program on their day of discharge to formally say goodbye to their peers and to the staff. The program provides a cake for those who are leaving, and the cake is cut and shared by the group and the clinical staff during the last fifteen minutes of the lunch break. Additionally, the staff writes a message in a card for the person that is leaving, and there is a piece of writing that is read aloud for them as well. The patients then write something on the reading for the person who is leaving, and the person being discharged can take these things home with them to remind them of their experiences in the PHP. This ritual is in place for many reasons: to promote a healthy ending to an experience and to encourage closure for the group member leaving, but also for those who will remain, to reframe goodbyes as a positive experience and to help create a smoother transition from the program back to their day-to-day life away from the program.

At the time of discharge, patients also filled out exit paperwork, which included the BASIS-32; the Perception of Care Survey; a qualitative, staff-created satisfaction survey (in part to assist with future programming, but this was not be a part of the analysis in this study); a list of current medications; scheduled follow-up appointments (the treatment team helps with linkage and appointments, as needed); scheduled return-to-work day,

when applicable; and a consent form if participants are agreeable to being contacted in one month, three month, and six month time intervals (this is being included here for information purposes only, as it is also not a part of this project).

Two Group Counseling Examples Specific to the Studied Site

An example of an art therapy group for the studied PHP that is conducted prior to the traditional therapy group is described next. Despite patients being at different stages in the program, the structured art therapy activity entitled "Group Mandala" is implemented to increase group cohesion, increase patients' level of risk taking, increase emotional disclosure among group members, and promote Yalom's (1995) curative factors, such as universality and instillation of hope. The materials needed for the group are a table large enough for all group members and the leader to sit around, a large piece of black craft or bulletin board paper (large enough that it covers the table), masking tape, oil pastels (either one box for each person or a box than can easily be shared by one to three people), and one pair of scissors (as needed). The group activity is divided into several parts and if timed properly, can easily be completed in sixty minutes.

All group members and the leader will be seated around the table with the black craft paper already laid out on the table prior to group starting. The group leader will start with a short welcome and will give the following directives in order:

1. Each member (counselor included) will choose an oil pastel and draw a circle about the size of a dinner plate (this guideline is to prevent very large or very small circles from being drawn) on the paper in front of them.

2. Each member will be asked to think about how to describe their "life theme" in the past month, taking into consideration feelings, thoughts, and experiences. The use of lines, shapes, and colors (no words/special characters and no stick figures) is strongly recommended to increase expressiveness and creativity in their visual response to the theme. Their images will be drawn within the circle (15 minutes).
3. Once everyone has completed their art piece, each person shares their image and explains what it means to them personally (10-15 minutes for the whole group).
4. After the sharing is complete, each person will take one oil pastel, and if they could relate to anyone's art piece or story, they will physically connect a line from their circle to someone else's (each member can connect to as many others in the group as they wish). They must physically connect their circles (drawing an arrow towards someone else's circle/image is not sufficient; 5 minutes or less).
5. Each group member will pick one person (for the sake of time) to whom they experienced the most connection and explain their reasoning. The group counselor encourages each group member to speak directly to the person they have a connection with versus speaking through the group leader; 10-15 minutes for the whole group). If time allows, group members may also share why they felt connected to others in the group.
6. After everyone has a chance to share, the group counselor will conclude by stating, "Since the art piece was made together, we need to unanimously decide what to do with the art piece". The group counselor can offer ideas if the group struggles to come up with anything, but the final decision needs to be a group one. The group

counselor will encourage participation from everyone and will discourage responses such as "whatever everyone else wants". All voices and opinions will be heard (5-10 minutes).

7. The group and group leader will follow through on whatever they collectively decide happens to the art piece.

This art therapy group has frequently created a turning point in the group. Often, group members and clinical staff will cite this group topic as beneficial in helping them feel more connected to one another and less alone. It is powerful due to the tangible nature of drawing a connection to peers and being able to capture the moment in a group art piece, which also creates a sense of cooperativeness in addition to cohesiveness. When a group is feeling stuck and disconnected, the more traditional clinicians have specifically asked that this group topic be implemented to assist in group cohesiveness. Corey (2015) asserts that "…changing group membership can have adverse effects on the cohesion of the group. Therefore, if the flow of the group is to be maintained, the leader needs to devote time and attention to…helping [new members] become integrated" (p. 91). This art therapy group topic allows for this to occur and carry over into other groups within the program.

The next example of an expressive therapy group centers on reflective writing in the program. Like the art therapy group example, this writing group is conducted prior to the traditional psychotherapy group. The reflective writing directive is to write a letter to someone (detailed later in the group description), and this is implemented to increase patients' level of risk taking, emotional disclosure among group members, and

empowerment/courage, and to provide them with an increased sense of trust and safety when addressing and processing a potentially emotional theme. The materials needed for the group are a journal/notebook paper and a writing instrument (pen or pencil). This group session is divided into two parts, and if timed properly, can easily be completed in sixty minutes.

All group members and the leader will be seated around a table and each person will have a journal given to them by the counselor (or if no journals are available, they are provided with notebook paper) and a writing utensil. The group leader will start with a short welcome, give a brief explanation of the writing group, and give the following directives in order:

1. The group counselor will write a topic on the whiteboard in the group room. For this group, the topic will be "Please write a letter to communicate something to another person. You can choose which direction you want to go. At the end of the group, you may choose to keep the letter, send it, destroy it, bury it, etc." Group members are strongly encouraged to consider something that may be difficult to communicate to the person and/or something they have wanted to communicate, but that they have not had the opportunity to reflect on or plan what they might say. The other stipulation for the members is they must write a letter to an actual person—not a pet, a fictional person or character (Tiny Tim, Bugs Bunny), or a religious or spiritual figure (God, Jesus, Buddha, etc.). They are also encouraged to write to someone they have a personal connection with and avoid people or entities such as the president, a

company, and so on. Past group members have taken these routes in the past and it has interfered with the group experience/process.

2. Each member will be asked to write on the topic for 20 to 30 minutes. They are encouraged not to censor themselves or worry about spelling or grammar, but rather just write what comes to mind, even if it doesn't seem to make sense. If group members finish early before others, they are asked to sit quietly and minimize talking and other disruptions so that others that are still writing can concentrate. The writing will take place at a table.
3. Once everyone has completed their writing at the table, they are asked to leave the table and come together as a group in a circle of chairs (without tables). The group room has a table and chairs on one side and a circle of chairs on the other side of the room. Group members are each asked to read their writings out loud, and every person will read before any questions, reactions, or feedback is given. This is important to make sure everyone has a chance to share their writing.
4. After the sharing is complete, the floor is open for group members to ask questions, give feedback, and share reactions to someone else's writing or add more they want to say about their own writing.

In leading this reflective writing group, it has frequently created strong reactions within the group. Often, group members and clinical staff will cite this group topic as beneficial in helping them feel more empowered to share their writings with the person they wrote about, while some will say that the topic has allowed them some closure to the situation, and others have said it gave them the opportunity to rehearse their words to face

a difficult situation. Group members almost always share that they felt inspired by others' writing. Others have tapped into their more creative side and were pleasantly surprised by their abilities. This group, similar to the art therapy group, creates a springboard for the theme to be carried throughout the rest of the treatment day and, in some cases, made part of their goals for the evening (i.e., "I have a goal tonight to share my letter with my husband.").

There are many aspects of groups that are beneficial and challenging. It is important for clinicians to find ways to incorporate both traditional and art/expressive therapies into group counseling settings. "It is essential to have [these] therapies built into the program and in regular use, so that patients with differing needs and abilities can approach issues in a variety of ways: verbal, nonverbal, visual, tactile, or kinetic" (Melson, 1995, p. 114). It should be understood, however, that while trained and licensed counselors are encouraged to use creative arts and expressive therapy approaches from time to time, ethically, art therapy should be practiced by those that have a master's degree in art therapy from institutions of higher education recognized by regional accreditation bodies approved by the Department of Education (American Art Therapy Association, 2015).

> State licensure laws and regulations prohibit a person from performing certain activities circumscribed by a particular profession's scope of practice, unless they hold a state license. Some states have art therapy licenses that delineate the legally permissible scope of practice for art therapists" (American Art Therapy Association, 2015, p. 1).

Previous Studies on Partial Hospitalization Programs

The research on partial hospitalization and intensive outpatient programs is limited. Currently, there are approximately 400 PHPs in the United States (Forgeard et al., 2018), however, the research centering on partial hospitalization and intensive outpatient programs remains scarce (Beard et al., 2016; Forgeard et al., 2018; Gerlinghoff, Herzog, & Beumont, 2002; Horovitz-Lennon et al., 2001; Houvenagle, 2015; Schene, 2004; Zipfel et al., 2001).

Granello, et al. (1999) offered a program evaluation approach of an effectiveness study, which is designed to "answer how well patients fare under treatment as it is actually practiced in the field and yield useful and credible information that can empirically validate psychotherapy" (p. 53). Granello et al.'s (1999) study aimed to answer four questions about the partial hospitalization program studied: 1) Do patients that attend PHP at that site leave with significantly lower levels of pathology at discharge versus admission? 2) Are any improvements that they do achieve sustained over time? 3) Do any demographic variables affect the success rate of the treatment in PHP? 4) Are patients satisfied with the treatment that they receive in PHP? (p. 54). The approach to answering these questions were to have patients (N = 287) complete the Brief Symptom Inventory (BSI) at admission, discharge, and at a 3-month follow up; the Client Satisfaction Questionnaire-8 (CSQ-8) at the time of discharge; and the Demographic Questionnaire at the time of admission. Twenty-one percent of participants completed the inventory at the 3-month follow up (N = 59). The data analysis used was a paired-sample *t* test to compare the mean scores of the BSI for all

participants (N= 287) at admission and at discharge. "The mean score at admission was 1.95 (T = 57) and 1.27 (T = 49) at discharge. This represents a statistically significant overall reduction in symptomology" (p. 56). For the follow up portion of the study, "no statistically significant difference was found for those from discharge (mean=1.45, T = 52) to follow-up (mean=1.59, T = 53)" (p. 56). To assess reduced symptoms from admission to discharge based on demographic variables, "seven two-way ANOVAs were used… Post hoc Tukey tests were run to determine which groups differed significantly at admission and discharge" (p. 57). The results of the CSQ-8 determined that participants were highly satisfied with their treatment.

Jensen (2001) examined BASIS-32 and Global Assessment Functioning scores at admission and discharge of a sample population of patients participating in a partial hospital program. Additionally, patient satisfaction surveys were examined, utilizing a mixed methods approach. Jensen (2001) sought to answer the following: 1) Do patients who receive treatment at the adult partial hospital program improve their level of symptom/functioning at discharge when compared to admission? 2) What is the level of patient satisfaction with the treatment they received while receiving partial hospital services? (p. 19). The sample size was 68 and of those, about half were able to complete the inventory at both intervals (36 participants). The Global Assessment of Functioning (GAF) was also assigned by clinicians to participants, at the time of intake and at the time of discharge.

The collected data included both quantitative and qualitative data. The quantitative data was analyzed using paired-sample *t*-test on the BASIS-32 scores at

admission and at discharge and the GAF score. Descriptive statistics were used to summarize demographics, clinical characteristics, and to analyze the qualitative data of the satisfaction surveys. The satisfaction survey asked participants what was most and least helpful and the data was examined for any emerging patterns and different themes using inductive logic. To determine changes in symptomology and functioning, the mean scores on the BASIS-32 and GAF were compared from admission to discharge. "The mean score at admission was 1.86 with a range of .71 to 3.03, and at discharge was 1.24 with a range of .14 to 2.69. This indicates a statistically significant overall improvement in symptoms/functioning ($t = 5.08$, $p < .01$)" (pp. 27-28). The GAF was also compared from admission to discharge, with the following results: "The mean score upon admission was 40.83 with a range of 30 to 55, and the mean score at discharge was 55.00, with a range of 40 to 70. This too indicates a statistically significant overall improvement in symptoms/functioning ($t = 12.88$, $p < .00$)" (p. 28).

Lenz, et al. (2014), utilized a mixed methods approach of sequential explanatory design, examining results of participants' responses to the Symptom Checklist-90-Revised (SCL-90-R) and the Relational Health Indices-Youth (RHI-Y). The researchers asked: To what degree is PHP treatment associated with changes from admission to discharge in the following: 1) the severity of mental health symptoms and 2) relational health. Thirdly, the researchers wanted to know what factors clients and counselors attribute to observed changes from admission to discharge. The methods used to answer these questions were to have the patients complete the SCL-90-R and RHI-Y at admission and at discharge. Additionally, qualitative, using semi-structured

interviews were conducted in focus groups. "The purpose of the focus groups was to elicit the clients' perceptions of therapeutic experiences within the PHP and develop the context for understanding the quantitative results" (Lenz, et al., 2014, p. 7). The statistical analyses employed for the quantitative data and a priori power analysis determine the number of participants needed to establish statistical power. It was determined that a sample size of 27 was needed. Paired-samples *t*-tests were used to assess for any statistically significance from admission to discharge.

Analyses for the qualitative data involved reviewing the transcripts from the interviews, creating meaning, and developing emergent themes. This was further distilled through textured descriptions of each theme. The research team triangulated the data through member checks by presenting the data to the focus groups for accuracy. Additionally, the researchers had "an expert auditor who was not involved in the current research project analyze the data to develop an independent set of themes. The convergence of themes derived from the audit to the original themes provided the second source of triangulation. Finally, the close fit between this study's qualitative and quantitative data sources offers additional verification to support the themes presented herein" (p. 8).

The quantitative results of paired samples *t*-tests revealed a number of statistically significant findings related to the changes in psychological symptoms over time for participants. The *t*-tests revealed that participants reported significantly fewer symptoms of anxiety, depression, paranoid ideation, and obsessive–compulsive ($t = 34$, $p < .01$). Participants also reported statistically significant changes in hostility, ($t = 34$,

$p < .01$), however, the rating of interpersonal sensitivity did not reveal meaningful change over time ($t = 34$, $p < .06$). "This suggests that despite endorsing fewer items related to aggression, resentment, or rage, participants continued to report similar levels of acute self-consciousness and self-directed resentment at discharge as they did when admitted to the PHP" (pp. 8-9).

The qualitative results revealed that "participants believed that prolonged stays in the PHP (i.e. more than 3 weeks) provided time to become stable, learn coping strategies, and practice them in a safe context" (p. 12). This research was able to conclude that "PHP programs may provide the structure and support that are required to promote adjustment and resilience" (p. 12).

Additional Studies on Patient Satisfaction

Patient satisfaction contributes to treatment follow through and adherence and increased benefits from treatment than those who are less satisfied with their care (Priebe & Miglietta, 2019). Many assessments measure patient satisfaction in mental health care. An extensive literature review revealed that the Client Satisfaction Questionnaire, the Client Assessment of Treatment Scale, the Verona Service Satisfaction Scale, and the Self-Rating Patient Satisfaction Scale were determined to provide the most useful results (Priebe & Miglietta, 2019).

Priebe and Miglietta (2019) also determined that "a number of socio-demographic characteristics such as gender, ethnicity, socio-economic and marital status have been suggested as determinants of satisfaction with care, but the associations are usually weak and the findings across studies are inconsistent. More substantial correlations

have been found with clinical characteristics and patient reported outcomes, such as subjective quality of life. Patients with higher symptom levels, especially more depressive symptoms, with personality disorders and with lower subjective quality of life tend to express less satisfaction with their care" (p. 31).

In another study measuring patient satisfaction, Fortin et al. (2018) utilized a conceptual framework based on "Andersen's behavioral model, comprising predisposing factors, enabling factors, and needs; socio-demographic, clinical, needs-related, service-use, and quality-of-life variables were integrated into the model" (p. 108). Using adjusted multiple linear regression models, the results were as follows: "the mean score on patient satisfaction for primary and specialized care was approximately 4 (range: 3.67–5.0). Results revealed a high level of patient satisfaction with each type of care, with significant variables related to continuity of care, case management, and needs. The study suggests the critical importance of addressing patient needs comprehensively, and of establishing long-term, individual recovery plans that promote patient satisfaction. Collaboration between relatives of patients and professionals in patient treatment is closely related to satisfaction with primary care" (pp. 111-112).

In this chapter, there was focus on how historical and current needs for mental health reform have been and are being addressed and how partial hospital and intensive outpatient programs are meeting some of the need, based on the literature reviewed. Group work, formulation, and facilitation were defined and discussed in detail, as well as the benefits of both traditional group counseling and art and expressive therapies in group counseling settings. A description of the therapeutic factors (Yalom, 1995), elements of

therapeutic process (Gunderson, 1978), suggestions for creating a supportive group environment, and the significance of therapeutic milieu to the PHP/IOP setting were also provided. Additionally, previous studies focusing on partial hospital programs, as well as further defining the partial hospital level of care, and identifying any gaps that exist in the literature, were also presented.

Chapter Three describes the methodology used in the study of archived data of the described program. Additionally, the outcome measures used will be described in detail, discussing the history, purpose, and the strengths and limitations of the measures used.

Chapter 3: Methodology

In this study I sought to determine the treatment outcomes and patient satisfaction in combined partial hospitalization (PHP) and intensive outpatient (IOP) programs for adults in an identified hospital in the Midwest region of the United States. The present investigation is modeled after the works of Lenz, et al. (2014); Jensen (2001); and Granello, et al. (1999), all of which measured treatment outcomes and client satisfaction in a partial hospitalization program.

While the current work is an effectiveness study, it is still important to note, briefly, the differences between effectiveness and efficacy studies. Efficacy studies focus on the measurable effects of specific interventions, utilize random treatment assignments and control groups, and prescribed treatment. Participants often are diagnosed with one disorder. Efficacy studies are typically meant for laboratory settings, providing the most opportunity for manipulating variables. Clinical trials are one example of efficacy research (Granello, et al., 1999; Nathan, Stuart, & Dolan, 2000). Because PHPs are viewed as naturalistic treatment, "...it is often difficult to use the 'gold standard' research designs, such as randomized controlled trials. Thus, almost all PHP research programs will focus on utilizing effectiveness research designs, with potentially great generalizability, but limited internal validity" (Forgeard, Beard, Kirakosian, & Bjorgvinsson, 2018, p. 214).

Guided by prior research on effectiveness of PHP/IOP programs, and inspired by the limited research on this topic, the current study was developed to examine the severity of mental health symptoms and functioning from admission to discharge of

participants in a combined PHP/IOP. The participants in this study were regularly exposed to both traditional and expressive arts counseling techniques as part of the multimodal PHP/IOP program. The study site was a rural hospital setting in the Midwestern region of the United States. The remainder of this chapter describes the methodology used, including the research objectives, variables, sampling plan and procedure, instrumentation and data collection procedures, and data analysis procedures.

Research Objectives

The objectives of the current research were to test the following research questions and hypotheses empirically:

RQ1: Will adults in a PHP/IOP program that utilizes both traditional and expressive group counseling show a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge?

H_o: Adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by the total scores on the BASIS-32 total.

RQ2: Will positive changes occur in relation to self and others, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to self and others as measured by Subscale 1 on the BASIS-32.

RQ3: Will positive changes occur in daily living and role functioning, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in daily living and role functioning, as measured by Subscale 2 on the BASIS-32.

RQ4: Will positive changes occur in depression and anxiety, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in depression and anxiety, as measured by Subscale 3 on the BASIS-32.

RQ5: Will positive changes occur in impulsive and addictive behaviors, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in impulsive and addictive behaviors, as measured by Subscale 4 on the BASIS-32.

RQ6: Will positive changes occur in relation to symptoms of psychosis, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to symptoms of psychosis, as measured by Subscale 5 on the BASIS-32.

RQ7: Will the level of patient satisfaction exceed the national average during a three-year period (2013-2015)?

This is a simple comparison and thus there is no hypothesis related to question seven.

Variables Used in the Study

There were three main outcome variables examined by the researcher. Data was collected from patients on eleven sociodemographic variables providing a more comprehensive description of the sample. All sociodemographic data were collected by

the demographic questions on the outcome measure (BASIS-32) and the records kept by the program for tracking purposes.

Outcome Variables

The three outcome variables were examined independently by the researcher. They are: (a) symptom severity; (b) independent functioning; and (c) participant satisfaction. The dependent variables *symptom severity* and *independent functioning* were operationalized based on the rating of difficulty from the BASIS-32 (0=no difficulty, 1=a little difficulty, 2=moderate difficulty, 3=quite a bit of difficulty, 4=extreme difficulty), which generates an overall mean score and five subscale scores (relation to self/others, daily living/role functioning, depression/anxiety, impulsive/addictive behavior, and psychosis; Eisen et al., 1999). The dependent variable of *patient satisfaction* was operationalized based on the ratings of satisfaction from the 13-item Perception of Care survey (1=poor, 2=fair, 3=good, 4=very good, 5=excellent; AABH, 2020).

Sociodemographic Variables

Sociodemographic information was collected to develop a more comprehensive description of the sample. Sociodemographic variables included: (a) admission type, (b) age, (c) diagnosis, (d) gender, (e) employment status, (f) number of treatment days, (g) payer source, (h) number of treatment days, (i) presence of dual diagnosis, (j) readmission status, and (k) referral source type.

Sampling Plan and Procedures

The Research Context

This quantitative study utilized a descriptive survey design and a pretest-posttest research design. A quantitative survey design is defined as a description of trends, attitudes, or opinions of a population by studying a sample of the identified population. Generalizations or inferences to the population will be made from the sample results (Creswell, 2014). The current research is an effectiveness study using data over a three-year period of clients in a PHP/IOP using a pretest-posttest design with a standardized instrument (the BASIS-32) to examine significant differences in participant scores between admission and discharge. The program site has been de-identified by the researcher throughout to maintain the confidentiality of the data and is hereafter referred to as *the Program.*

The Program is housed in a regional campus of a large hospital organization in the Midwest region of the United States. The Program serves approximately 100 patients per year at the regional site.

Population

The target population for this study was adults, aged 18 or older, that were admitted to and discharged from the Program, and who were able to complete the BASIS-32 at the time of admission and were able to complete a BASIS-32 and Perception of Care survey at the time of discharge. The time period for which date were analyzed was from 2013-2015. Exclusion criteria included anyone under the age of 18, anyone that did not complete the BASIS-32 at both admission and discharge, or anyone

that stopped treatment prior to discharge. Additionally, any surveys that were incomplete were excluded.

Sampling Procedure

Due to the data being archived, all participant data that met the inclusionary criteria were used in the study from a three-year period, 2013-2015. The BASIS-32 results were only available through 2015, as the site's license to use the resources for the instrument was not renewed beyond 2015 due to cost barriers. During 2013-2015, data from 292 participants were collected. However, after inclusionary and exclusionary factors were considered, the sample generated 171 participants (N = 171).

Instrumentation and Data Collection Procedures

The data were accessed by the researcher from archived data maintained by the *Program*. The archived data kept by the *Program*, included the following: (a) sociodemographic questions, (b) inclusionary criteria, (c) the BASIS-32 pre and post-test scores (Eisen, et al., 1986), and (d) the Perception of Care Survey (AABH, 2020).

Informed Consent and Inclusion Criteria Questions

Informed consent was not required for this study, as the study was conducted using archived data and none of the archived data presented were linked to an individual participant. Additionally, inclusion criteria were assessed.

The first inclusion criteria assessed was age. Age was indicated by self-report to the *Program* that collected the data. Participant age was delimited to anyone over the age of 18. If age was reported as 17 or under or not collected, this participant's data was not included in the study.

The second inclusion criteria assessed was completion of the BASIS-32 at both admission to and discharge from the Program. If both were present, then the scores were included in the study. If one or no scores were present, they were not included. Because completion of the BASIS-32 was completed on the date of admission and the date of discharge, this implied that the participant has completed the program, which was the third inclusion criteria assessed.

The fourth inclusion criteria assessed was the completion of the Perception of Care survey. This information was be obtained by examining the archived data kept by the *Program*.

Sociodemographic Variable Questions

For all participants from the archived data set that met inclusion criteria for the study, the following sociodemographic descriptors were examined (based on the data previously collected from the *Program*): gender, race, employment status, admission type, readmission status, the number of days attended in PHP, the number of days attended in IOP, admitting diagnosis, payer source, referral source type, and presence of a dual diagnosis. Age was an additional sociodemographic variable assessed in the inclusion criteria.

Gender

Due to the time period studied, gender was limited in the archived data to male or female. It did not take into consideration more specific options such as transgender or non-binary.

Race

Race was indicated by self-report to a multiple-option multiple choice question, "What is your race?" The answer options were "Black/African American", "White/Caucasian", "Asian/Pacific Islander", "American Indian/Alaskan", or "Multiracial/Other".

Employment Status

Employment status was indicated by self-report and available from the archived data. There were only two options to choose from: employed or not employed. The archived data did not offer what type of employment (i.e., part-time, full-time, etc.).

Admission Type

Admission type was identified by *Program* staff and included one of two options: direct or transition admission. Direct admission was a participant that was referred by a non-inpatient source. This non-inpatient source could also include self, family member, or friend, in addition to other referral sources (i.e., doctor, counselor, employer, etc.). Transition admissions included any participants referred to the *Program* from an inpatient behavioral health unit setting.

Readmission Status

Readmission status was identified by *Program* staff as any participant that had attended the program previously for any length of time. This included any admissions that completed or did not complete the program previously.

Days of Attendance in PHP and IOP

The total days of attendance in PHP and IOP were identified by Program staff and available in the archived data. Despite the Program combining PHP and IOP services, the data for the number of days attended were captured by each level of care separately.

Admitting Diagnosis

The admitting diagnosis information was available from the archived data kept by the *Program*. It included the primary diagnosis of the participant at the time of admission, as determined by the primary counselor, attending physician, and other members of the Program treatment team.

Payer Source

The primary payer sources for services received in the Program was determined from the following categories, as identified by the archived data: “Medicare”, “Medicaid (including managed Medicaid)”, “Private Insurance”, “Self-Pay”, “Bureau of Worker’s Compensation (BWC)”, or “Other”.

Referral Source Type

The referral source type was determined from the following categories, as identified by the archived data: “Community Mental Health Agency”, “Emergency Room”, “Employer”, “Family Member”, “Friend”, “Inpatient Behavioral Health Unit”, “Inpatient Medical Floor”, “Insurance Company”, “Outpatient Counselor/Social Worker/Psychologist Office”, “Outpatient Psychiatrist Office”, “Primary Care Physician Office”, “School”, “Self”, or “Other (any other referral source type that did not fit in any of the previous categories)”.

Presence of a Dual Diagnosis

Presence of a dual diagnosis, as examined in the archived data, included any participant that had an active mental health and substance abuse or dependency diagnosis. Any participant that carried a substance abuse or dependency diagnosis that was classified as "in full sustained remission" was excluded from this variable.

Behavior and Symptom Identification Scale-32

In addition to the variables described above, the archived data included participant responses to the BASIS-32 (Eisen & Grob, 1986), which measured change in symptoms and level of functioning from the participant's perspective. It is a brief yet comprehensive instrument that "cuts across" diagnoses by identifying a wide range of symptoms and problems that occur across the diagnostic spectrum. The BASIS-32 allows evaluation of change over the course of treatment. The survey measures the degree of difficulty experienced by the patient during a one-week period on a five-point scale ranging from 0 (no difficulty) to 4 (extreme difficulty). It is scored using an algorithm that gives an overall score with five subscales for the following domains of psychiatric and substance abuse symptoms and functioning: relation to self and others, daily living and role functioning, depression and anxiety, impulsive and addictive behavior, and psychosis (Eisen & Grob, 1986; McLean Hospital, 2016). Items 7, 8, 10, 11, 12, 14, and 15 of the survey comprise the relation to self and others subscale. Items 1, 2, 3, 4, 5, 13, 16, 21, and 32 of the survey comprise the daily living and role functioning subscale. Items 6, 9, 17, 18, 19, and 20 of the survey comprise the depression and anxiety subscale. Items 25, 26, 28, 29, 30, and 31 of the survey

comprise the impulsive and addictive behavior subscale. Items 22, 23, 24, and 27 of the survey comprise the psychosis subscale (Eisen et al., 1999).

The highest total score for each subscale is as follows: relation to self and others: 28; daily living and role functioning, 36; depression and anxiety, 24; impulsive and addictive behavior, 24; and psychosis, 16. Adding the five subscales together produces a composite measure of behavior and symptoms, with the highest score being 128. Higher scale or total scores on the BASIS-32 indicate a greater severity or frequency in symptoms and behaviors. To determine the severity (i.e., no difficulty, a little difficulty, moderate difficulty, quite a bit of difficulty, extreme difficulty), the subscale total scores would be divided by the number of items representing each subscale, which would produce a score of 0 for no difficulty, 1 for a little difficulty, 2 for moderate difficulty, 3 for quite a bit of difficulty, and 4 for extreme difficulty. The mean score of all items would determine the severity of all areas, using the same severity scale. The BASIS-32 assesses for symptoms experienced in the past two weeks, and therefore emphasizes the affective states of depression, anxiety, impulsive and addictive behavior, and psychosis; the level of functioning in relation to self and others; and daily living and role functioning, rather than traits. The BASIS-32 is not intended to result in the clinical diagnosis of mental health disorders, such as major depressive disorder, generalized anxiety disorder, bipolar disorder, thought disorders, nor the identification of recommended treatment interventions.

Psychometric Properties

Eisen et al. (1999) determined that the BASIS-32 is a psychometrically sound instrument with technical quality, based on their study to determine its appropriateness as an outcome measure for individuals receiving ambulatory mental health services. Previously, the measure was only utilized for individuals receiving inpatient care for mental health reasons (Eisen & Dickey, 1996; Eisen, et al., 1994; Hoffman, et al., 1997; Russo et al., 1997). A study to measure soundness and quality for ambulatory settings (Eisen et al., 1999) included clinical participants that attended a partial hospital program and completed a BASIS-32 at intake (n = 407) and again during follow up contact in 30 to 90 days (n = *228).* The participants reportedly had various diagnoses, including major depression (45%), anxiety and dissociative disorders (15%), psychotic disorders (12%), adjustment disorders (10%), diagnoses originating in childhood (4%), eating disorders (2%), and other diagnoses (4%). The factor structure of the BASIS-32 was originally determined by the sample of those receiving inpatient care. "Exploratory factor analysis had been used to derive clusters or symptoms and problems that held together as a factor. Since factor structure served as the framework for deriving the five subscales, it [was] important to determine whether the same subscales applied to individuals receiving treatment at less intense levels of care" (Eisen et al., 1999, p. 9). A confirmatory analysis was performed and "provided adequate confirmation of the original factor structure that had been determined on an inpatient sample" (p. 14). Cronbach's Alphas coefficients for the BASIS-32 subscales were as follows: relation to self and others: 0.89; depression and anxiety: 0.87; daily living and role functioning:

0.88; impulsive and addictive behavior: 0.65; psychosis: 0.66. The full-scale reliability for all 32 items was 0.95. Moreover, the BASIS-32 was found to correlate highly with other known measures, such as the Short Form Health Status Profile (SF-36;Ware & Sherbourne, 1992); the Mental Health Component Scale (MCS; Blais et al., 1999); and the Satisfaction with Life Scale (Diener, et al., 1985), which ranged from r = .59 to .82, suggesting high concurrent validity (Eisen, et al., 2006). There are many additional studies for reference that support the validity and reliability of the BASIS-32 (Deady, 2009; Eisen et al., 2011; Eisen et al., 1999; Stedman et al., 2000). Finally, a major strength of this measure is its applicability to a wide range of people receiving mental health treatment. The measure is simple and brief, so it can be administered by nonprofessional personnel. The BASIS is part of a performance measurement system approved by the Joint Commission on Accreditation of Healthcare Organizations (JAHCO; Eisen & Grob, 1986).

Perception of Care Surveys

The Perception of Care Surveys, which are sanctioned by the American Ambulatory Behavioral Health (AABH) organization, are used to measure participants' levels of satisfaction in several areas. Twelve areas are measured, and participants rate each item using a 5-point response scale (5=excellent, 4=very good, 3=good, 2=fair, 1=poor). The twelve areas include: (a) comfort of the facility, (b) ease of the admission process, (c) helpfulness of the staff, (d) value of group interventions, (e) active role in the treatment process, (f) perceived impact on life activities, (g) perceived impact on helpfulness, (h) feelings of safety outside the program, (i) effectiveness of the

prescribing professional, (j) program impact on recovery, (k) preparedness for discharge, and (l) overall satisfaction (AABH, 2020). The scores from the studied site were compared against national averages of other PHP/IOPs, which were obtained from the Spectrum of Statistics, the consulting firm that collects and analyzes the data for AABH. The research questions that guided this study are presented next.

Research Questions

RQ1: Will adults in a PHP/IOP program that utilizes both traditional and expressive group counseling show a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge?

H_o: Adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by the total scores on the BASIS-32 total.

RQ2: Will positive changes occur in relation to self and others, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to self and others as measured by Subscale 1 on the BASIS-32.

RQ3: Will positive changes occur in daily living and role functioning, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in daily living and role functioning, as measured by Subscale 2 on the BASIS-32.

RQ4: Will positive changes occur in depression and anxiety, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in depression and anxiety, as measured by Subscale 3 on the BASIS-32.

RQ5: Will positive changes occur in impulsive and addictive behaviors, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in impulsive and addictive behaviors, as measured by Subscale 4 on the BASIS-32.

RQ6: Will positive changes occur in relation to symptoms of psychosis, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to symptoms of psychosis, as measured by Subscale 5 on the BASIS-32.

RQ7: Will the level of patient satisfaction exceed the national average during a three-year period (2013-2015)?

This question had no hypothesis as a simple comparison with national data was conducted.

Data Analysis Procedures

This research study is an effectiveness study that analyzed data over a three-year period (2013-2015) of clients in a PHP/IOP using a pretest-posttest design utilizing a standardized instrument (the BASIS-32) to examine significant differences in total and sub-scale scores between admission and discharge. Paired *t*-tests, along with descriptive statistics, were used to analyze the data for the BASIS-32. The patient satisfaction surveys were part of archived data that was compared to national data for PHP/IOPs and are included in the results.

Based on previous studies on Partial Hospitalization, there has been a need to re-invigorate interest in PHP as a viable and necessary level of care, and this research addressed a few key areas. The goals of the researcher were to expand the research for group counseling and creativity in counseling, and to focus more attention on PHPs that offer both traditional and art/expressive counseling approaches. In addition, the study examined the symptomology of participants at the time of admission and discharge to a combined PHP and intensive outpatient program (IOP) that employs traditional and creative approaches to group counseling.

Archived data, including demographic information and symptomology and level of functioning as measured by the Behavior and Symptom Identification Scale (BASIS-32) at the time of intake and discharge from the program for patients admitted and discharged from 2013-2015 was used in this study. Furthermore, the research also examined participants' level of satisfaction by their responses to the Perception of Care Surveys, sanctioned by the American Ambulatory Behavioral Health organization, which were compared against national averages of other PHP/IOPs in the United States. The BASIS-32 results were examined using historical data from participants admitted and discharged from the combined PHP/IOP over a three-year period (2013-2015). Similarly, the results of the Perception of Care Surveys were examined using historical data from participants in the combined program over the same three-year period.

In this chapter the methodology used in the study was described. Outcome measures used in the study were described in detail, including the history, purpose, and

the strengths and limitations of the measures used. In Chapter Four the results of the study are presented.

Chapter 4: Results

There is limited research on effectiveness studies for partial hospital and intensive outpatient programs and patient satisfaction. Thus, the main goal of this current effectiveness study was to address this gap in the literature by increasing the knowledge base of treatment outcomes and patient satisfaction. Effectiveness studies seek to "answer how well patients fare under treatment as it is actually practiced in the field and yield useful and credible information that can empirically validate psychotherapy" (Granello, et al., 1999, p. 53). The research questions assessed if the severity of mental health symptoms of participants decreased and if functioning increased in those that attended the combined partial hospitalization and intensive outpatient program.

Research Questions

The following research questions guided the study:

RQ1: Will adults in a PHP/IOP program that utilizes both traditional and expressive group counseling show a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge?

H_o: Adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by the total scores on the BASIS-32 total.

RQ2: Will positive changes occur in relation to self and others, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to self and others as measured by Subscale 1 on the BASIS-32.

RQ3: Will positive changes occur in daily living and role functioning, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in daily living and role functioning, as measured by Subscale 2 on the BASIS-32.

RQ4: Will positive changes occur in depression and anxiety, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in depression and anxiety, as measured by Subscale 3 on the BASIS-32.

RQ5: Will positive changes occur in impulsive and addictive behaviors, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in impulsive and addictive behaviors, as measured by Subscale 4 on the BASIS-32.

RQ6: Will positive changes occur in relation to symptoms of psychosis, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to symptoms of psychosis, as measured by Subscale 5 on the BASIS-32.

RQ7: Will the level of patient satisfaction exceed the national average during a three-year period (2013-2015)?

This question had no hypothesis as a simple comparison with national data was conducted.

Demographic Information and Clinical Characteristics of the Sample

The sample consisted of 171 participants presenting for treatment in a combined PHP/IOP program (N =171). The study participants' age ranged from 18 to 84 years. The mean age was 42.32 years (SD = 12.67). The sample represented 43 males (25.1%) and 128 females (74.9%). The population was 99.4% White/Caucasian (n = 170) and 0.6% Black/African American (n = 1). The diagnoses represented in the sample included Major Depression (n = 121 or 70.8%), Bipolar Disorder (n = 37 or 21.6%), Schizoaffective Disorder (n = 8 or 4.7%), Generalized Anxiety Disorder (n = 1 or 0.6%), and Other (n = 4 or 2.3%). A summary of the sample's demographic and clinical characteristics are presented in Table 1 and Table 2.

Table 1

Demographic Sample and Clinical Characteristics (N = 171)

	n	%
Gender		
Female	128	74.9
Male	43	25.1
Race		
Black/African American	1	0.6
White/Caucasian	170	99.4
Diagnosis		
Bipolar Disorder	37	21.6
Generalized Anxiety Disorder	1	0.6
Major Depression	121	70.8
Schizoaffective/Schizophrenia	8	4.7
Other	4	2.3
Admission Type		
Direct	118	69
Transition	53	31
Readmission		
No	120	70.2
Yes	51	29.8
Employed		
No	76	44.4
Yes	95	55.6
Dual Diagnosis		
No	139	81.3
Yes	32	18.7
Payer Source		
Medicaid	34	19.9
Medicare	23	13.5
Private Insurance	108	63.2
Self-Pay	6	3.5

Table 1: continued

	n	%
Referral Source		
Behavioral Health Unit	52	30.4
Community Mental Health Center	17	9.9
Emergency Department	4	2.3
Employer	1	0.6
Friend	3	1.8
Insurance	1	0.6
Medical Floor	3	1.8
Primary Care	3	1.8
Psychiatrist	53	31
Self	18	10.5
Therapist	11	6.4
Other	5	2.9

Table 2

Age and Number of PHP and IOP days (N = 171)

Variable	Min	Max	*M*	*SD*
Age	18	84	42.32	12.67
PHP Days	0	35	17.82	0.78
IOP Days	0	26	3.55	0.40

To determine changes in symptomology and functioning, the mean BASIS-32 subscale scores and standard deviations were measured and compared from admission to discharge. Additionally, the overall mean scores were compared from admission to discharge. The *p* value is impacted by sample size, supplemented by effect size, based on

Cohen's guidelines to interpret effect size: small (0.20), medium (0.50), and large (0.80). The assumption of normality of different scores have been checked and the assumption has been met for BASIS-32 Subscales 1, 2, 3, and the overall scores. For Subscale 4 ($p <$ .001) and Subscale 5, the assumption of normality has been violated ($p < .001$). This could be explained by outliers, however, the outliers were legitimate responses, therefore, were not eliminated. Nevertheless, the researcher attempted to remove three outliers from Subscale 4, the results revealed that the tests of normality was still violated. It would be difficult to be normally distributed based on the nature of the changed score of Subscale 4, when looking at the histogram scores of the other subscales. The *N* is not small, so it is indicative that there is something about the nature of Subscale 4. For Subscale 5, there were five outliers, however, the results remained significant (i.e., the assumption of normality was violated) when the outliers were removed. This is about consistency of scores produced by the instrument, but based on previous studies, this is not uncommon with Subscales 4 and 5. Thus the results are interpreted with caution. The descriptive statistics for Subscales 1-5 and overall scores for admission and discharge are presented in Table 3 and Figures 1 and 2.

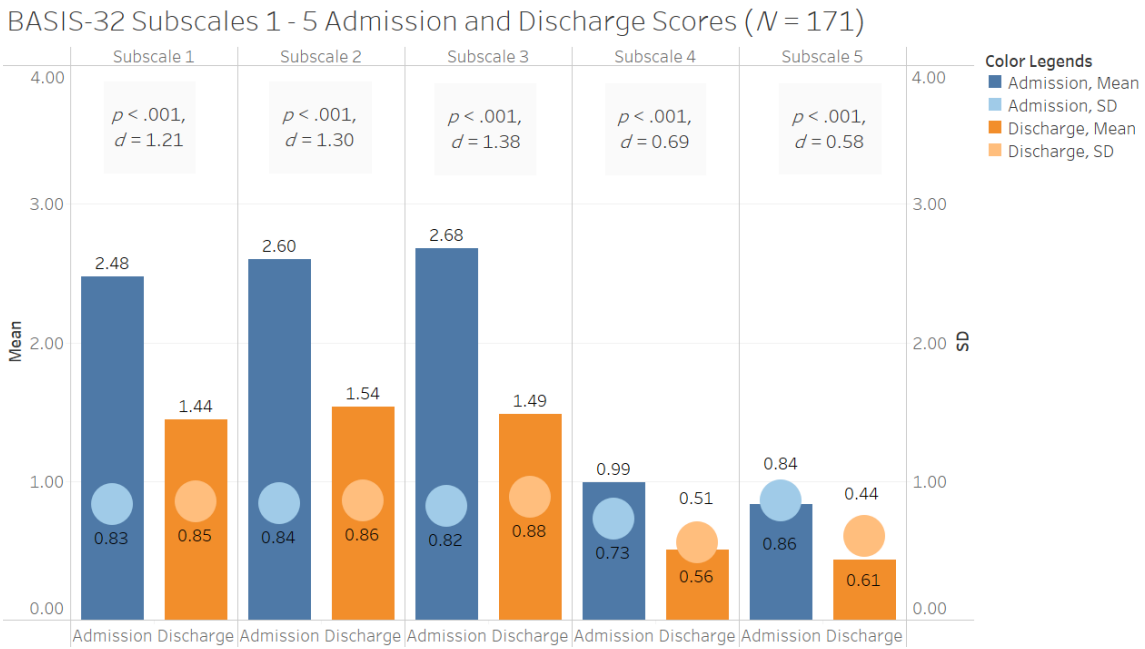
Table 3

Subscales 1-5 and Overall Score at Admission and Discharge

	Admission			Discharge		
Subscale	*M*	*SD*	*N*	*M*	*SD*	*N*
1: Relation to Self/Others	2.48	0.83	171	1.44	0.85	171
2: Daily Living & Role Function	2.60	0.84	171	1.54	0.86	171
3: Depression & Anxiety	2.68	0.82	171	1.49	0.88	171
4: Impulsive & Addictive Behavior	0.99	0.73	171	0.51	0.56	171
5: Psychosis	0.84	0.86	171	0.44	0.61	171
Overall Score	9.59	3.29	171	5.41	3.24	171

Figure 1

BASIS-32 subscales 1-5 admission and discharge scores



Findings Reported for each Research Question

RQ1: Will adults in a PHP/IOP program that utilizes both traditional and expressive group counseling show a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge?

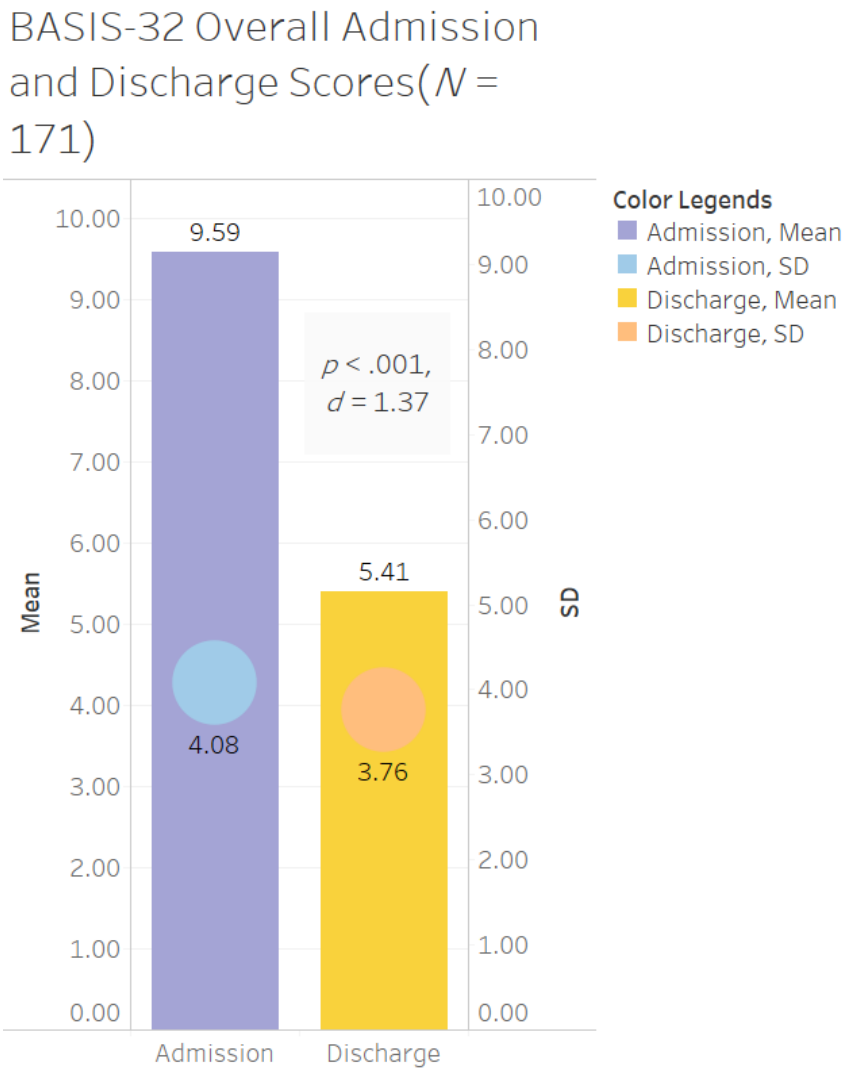
H_o: Adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by the total scores on the BASIS-32 total.

Paired t-Test: Overall Scores of BASIS-32

The overall mean score was calculated by combining the five subscales. The overall mean score at admission was 9.59 (SD = 3.29), with a minimum value of 0.1 and a maximum of 17.5. At the time of discharge, the mean score was 5.41 (SD = 3.24), with a minimum value of 0.4 and a maximum of 17.2. This indicates a statistically significant improvement in the overall mean score from admission to discharge $t(170) = 17.93$, $p < .001$, $d = 1.37$. A commonly used interpretation is to refer to effect sizes as small ($d = 0.2$), medium ($d = 0.5$), and large ($d = 0.8$) (Cohen, 1988). There was a large effect size per Cohen's (1988) interpretation of effect size. Thus, the null hypothesis was rejected.

Figure 2

BASIS-32 overall admission and discharge scores



RQ2: Will positive changes occur in relation to self and others, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to self and others as measured by Subscale 1 on the BASIS-32.

Paired t-Test: Subscale 1 of the BASIS-32 – Relation to Self and Others

The first subscale, Relation to Self and Others, refers to relationships with family members, being able to feel close to others, being realistic about oneself and others, getting along with people outside of the family, having goals and direction in life, and lack of self-confidence or feeling bad about oneself (Eisen, 1994). The mean score at admission was 2.48 (SD = 0.83), with a minimum value of 0.1 and a maximum of 4.0. At the time of discharge, the mean score was 1.44, with a minimum value of 0.0 and a maximum of 3.8 (SD = 0.85). This indicates a statistically significant improvement in relation to self and others, $t(170) = 15.78$, $p < .001$, $d = 1.21$ with a large effect size per Cohen (1988). Higher scores reflect less confidence and feeling bad. Thus, the null hypothesis for research question 2 was rejected.

RQ3: Will positive changes occur in daily living and role functioning, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in daily living and role functioning, as measured by Subscale 2 on the BASIS-32.

Paired t-Test: Subscale 2 of the BASIS-32 – Daily Living and Role Functioning

The second subscale, Daily Living and Role Functioning, assessed how the participant: managed day to day life (i.e., deciding what to wear, what to eat, self-care

including dressing, bathing); structured their time and found things to do (leisure); developed independence and autonomy (financially, emotionally, and socially); degree of apathy or lack of interest in things; level of confusion, concentration, and memory; and how satisfied they felt in life. Additionally, how the participant was managing household responsibilities, work, and/or school (Eisen, 1994). The mean score at admission was 2.60 (*SD* = 0.85), with a minimum value of 0.0 and a maximum of 4.0. At the time of discharge, the mean score was 1.54 (*SD* = 0.86), with a minimum value of 0.0 and a maximum of 4.0. This indicates a statistically significant improvement in daily living and role functioning, $t(170) = 16.98$, $p < .001$, $d = 1.30$, with a large effect size per Cohen (1988). Higher scores reflect less confidence and feeling bad. Thus, the null hypothesis for research question 3 was rejected.

RQ4: Will positive changes occur in depression and anxiety, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in depression and anxiety, as measured by Subscale 3 on the BASIS-32.

Paired t-Test: Subscale 3 of the BASIS-32 – Depression and Anxiety

The third subscale addressed Depression and Anxiety. Specifically, this subscale investigates how a participant is adjusting to major life stresses; levels of isolation, loneliness, depression, hopelessness, suicidal feelings or behavior, physical symptoms, fear, anxiety, and panic (Eisen, 1994). The mean score at admission was 2.68 (*SD* = 0.82), with a minimum value of 0.0 and a maximum of 4.0. At the time of discharge, the mean score was 1.49 (*SD* = 0.88), with a minimum value of 0.0 and a

maximum of 4.0. This indicates a statistically significant improvement in depression and anxiety $t(170) = 18.01$, $p < .001$, $d = 1.38$, with a large effect size per Cohen (1988). Thus, the null hypothesis for research question four was rejected.

RQ5 : Will positive changes occur in impulsive and addictive behaviors, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in impulsive and addictive behaviors, as measured by Subscale 4 on the BASIS-32.

Paired t-Test: Subscale 4 of the BASIS-32 – Impulsive and Addictive Behaviors

The fourth subscale examined Impulsive and Addiction factors. This subscale was interested in the participant's experience with mood swings, unstable mood, uncontrollable and/or compulsive behavior, drinking alcoholic beverages, taking illegal drugs or misusing prescribed medications, control of temper, outbursts of anger or violence, and impulsive, illegal, or reckless behavior (Eisen, 1994). The mean score at admission was 0.99 ($SD = 0.73$), with a minimum value of 0.0 and a maximum of 2.8. At the time of discharge, the mean score was 0.51 ($SD = 0.56$), with a minimum value of 0.0 and a maximum of 3.0. This indicates a statistically significant improvement in impulsive and addictive behaviors $t(170) = 9.00$, $p < .001$, $d = 0.69$, with a small effect size per Cohen (1988). Thus, the null hypothesis for research question 5 was rejected.

RQ6 : Will positive changes occur in relation to symptoms of psychosis, between admission and discharge?

$H_{o:}$ No change in a positive direction will occur in relation to symptoms of psychosis, as measured by Subscale 5 on the BASIS-32.

Paired t-Test: Subscale 5 of the BASIS-32 – Symptoms of Psychosis

The fifth subscale refers to symptoms of Psychosis. These items addressed if the participant experienced disturbing or unreal thoughts or beliefs, hearing voices, seeing things, manic and/or bizarre behaviors, and sexual activity or preoccupation (Eisen, 1994). The mean score at admission was 0.84 (*SD* = 0.86), with a minimum value of 0.0 and a maximum of 3.8 (maximum score of the sample population, not the maximum score of the instrument). At the time of discharge, the mean score was 0.44 (*SD* =0.61), with a minimum value of 0.0 and a maximum of 3.0. This indicates a statistically significant improvement in relation to self and others $t(170) = 7.61$, $p < .001$, $d = 0.58$, with a small effect size per Cohen (1988). Thus, the null hypothesis for research question 6 was rejected. The results of the Paired Sample *t*-tests for the five subscale and overall scores from the BASIS-32 are presented in Table 4.

Table 4

BASIS-32 Subscales 1-5 and Overall Scores at Admission and Discharge: Paired Samples Test

Subscale	*M*	*SD*	*N*	95% CI for Mean Difference	*t*	*df*	*p*	*d*
1: Relation to Self/Others	1.03	0.86	171	[0.90, 1.16]	15.8	170	< .001	1.21
2: Daily Living & Role Function	1.07	0.82	171	[0.95, 1.19]	16.98	170	< .001	1.30
3: Depression & Anxiety	1.19	0.87	171	[1.06, 1.33]	18.01	170	< .001	1.38
4: Impulsive & Addictive Behavior	0.48	0.70	171	[0.38, 0.59]	9.00	170	< .001	0.69
5: Psychosis	0.40	0.69	171	[0.30, 0.51]	7.61	170	< .001	0.58
Overall Admission and Discharge	4.18	3.05	171	[3.72, 4.64]	17.93	170	< .001	1.37

Patient Satisfaction

RQ7: Will the level of patient satisfaction exceed the national average during a three-year period (2013-2015)?

To answer research question seven of whether the level of patient satisfaction would exceed the national average during a three-year period (2013-2015), the Perception of Care surveys administered were scored and compared with the national average of other PHP/IOP programs. This is a simple comparison and thus there is no hypothesis related to question seven. The overall results are below in Table 5.

Table 5

Total Scores for Perception of Care from 2013-2015 and National Average

Year	Program Total Overall	National Average Total Overall
2013	4.55	4.36
2014	4.33	4.38
2015	4.45	4.37

The Perception of Care scores of the PHP/IOP of study, compared to the National Average (United States), demonstrated very small differences: 0.19 in 2013, 0.05 in 2014, and 0.08 in 2015. These differences indicate that patient satisfaction in the program during 2013-2015 was very similar to the national average.

In Chapter Four, the results of the analyses were reported. In Chapter Five, I present a review of findings, and discuss limitations of the study, implications for various stakeholders, and recommendations for future research.

Chapter 5 Discussion

Overview of the Study

There is limited research on effectiveness studies for partial hospital and intensive outpatient programs and patient satisfaction. The main goal of this effectiveness study was to address this gap in the literature by increasing the knowledge base for treatment outcomes and patient satisfaction in partial hospitalization and intensive outpatient programs. Effectiveness studies seek to "answer how well patients fare under treatment as it is actually practiced in the field and yield useful and credible information that can empirically validate psychotherapy" (Granello, et al. 1999, p. 53). The research questions assessed if the severity of mental health symptoms decreased and functioning increased in those that attended the combined partial hospitalization and intensive outpatient program. Additionally, demographic information, such as gender, age, race, employment status, and presence of dual diagnosis (defined as a mental disorder combined with a substance abuse disorder), were also offered to understand the sample population.

The symptoms and functioning were measured by the BASIS-32 at the time of admission and discharge from the program. The BASIS-32 also measured five subscales and the overall scores. The five subscales examined relation to self and others, daily living and role function, depression and anxiety, impulsive and addictive behaviors, and psychosis. The researcher also examined participants' level of satisfaction by their responses to the Perception of Care Surveys, sanctioned by the American Ambulatory Behavioral Health organization and these scores were compared to the national averages

of other PHP/IOP's. The national average scores were calculated by the Spectrum of Statistics and included responses to thirteen questions.

The researcher addressed gaps in the literature by increasing the knowledge base of treatment outcomes and patient satisfaction. The research study answered the overarching research question if adults in a combined partial hospital and intensive outpatient program that utilizes both traditional and expressive group counseling showed a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge; if changes in behavioral and emotional functioning occurred based on the analysis of subscales from the outcome measure; and if the level of patient satisfaction exceeded the national average during a three-year period. Descriptive statistics of central tendency and variability, including gender, age, race, employment status, and presence of dual diagnosis (defined as mental disorder combined with substance abuse disorder), were also examined.

The results of this study are beneficial to various stakeholders, including counselors, counselor supervisors, counselor educators, payer sources, and AABH, among others, to further support PHP and IOP as a valid and necessary form of treatment to reduce relapse, prevent hospitalization, reduce costs, and improve the overall well-being of patients with acute mental health disorders. This chapter includes an overview of the purpose and significance of the present study and a discussion of the results. Implications for the field of counseling, partial hospitalization and intensive outpatient programs, and stakeholders are discussed. Lastly, the limitations of the study are reviewed, and recommendations for future research are presented.

Review of Findings

The highest possible total score for the BASIS-32 is 128. To determine the severity, the subscale total scores were divided by the number of items representing each subscale, and this produced a score of 0 for no difficulty, 1 for a little difficulty, 2 for moderate difficulty, 3 for quite a bit of difficulty, and 4 for extreme difficulty. The mean score of all items were used to determine the severity of all areas, using the severity scale described above. Higher scores indicated a greater severity or frequency in symptoms. The mean score for the subscale of relation to self and others among this sample was 2.48 at the time of admission, indicative of moderate difficulty in this area. At the time of discharge, the mean score was 1.44, indicative of lower level of difficulty in this area (Eisen, 1994). The mean score for the subscale of daily living and role function among this sample was 2.60 at the time of admission, indicative of moderate difficulty in this area. At the time of discharge, the mean score was 1.54, indicative of low difficulty in this area (Eisen, 1994). The mean score for the subscale of depression and anxiety among this sample was 2.68 at the time of admission, indicative of moderate difficulty in this area. At the time of discharge, the mean score was 1.49, indicative of low difficulty in this area (Eisen, 1994). The mean score for the subscale of impulsive and addictive behavior among this sample was 0.99 at the time of admission, indicative of little difficulty in this area. At the time of discharge, the mean score was 0.51, indicative of little difficulty in this area (Eisen, 1994). The mean score for the subscale of psychosis among this sample was 0.84 at the time of admission, indicative of little difficulty in this area. At the time of discharge, the mean score was 0.44, indicative of no difficulty in this area (Eisen, 1994). The scores for impulsive and addictive behavior

and psychosis among this sample could be explained by the relatively small number of participants diagnosed with a psychotic disorder (4.7%) or a substance abuse disorder (18.7%). This explanation is supported from previous studies with similar results for the subscales of impulsive and addictive behavior and psychosis (Eisen, et al., 1997). In other words, previous studies by Eisen, et. al (1997), indicate that clients in PHP/IOP tend not to have psychotic or substance abuse disorders (or a very low percentage). Those that have impulsive and/or addictive behaviors and/or psychosis symptoms would likely be best served in other settings or with other services. Examples could include ongoing case management services, substance abuse specific IOP, day treatment centers that are more long term, etc. It is understood that participants in a PHP/IOP are expected to benefit from the level of care and must be able to tolerate the milieu.

Overall Symptom and Function Improvement

The first research question of this study was to determine if adults in a combined partial hospital and intensive outpatient program showed an overall decrease in severity of mental health symptoms and an increase in functioning between admission and discharge. Based on previous research, the H_o = adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by the total scores on the BASIS-32. Symptom and function improvement were defined by lower total scores on the BASIS-32 comparing data collected at admission to data collected just prior to discharge. Analyses of a pre and post-test using the BASIS-32 total scores with a paired *t*-test were completed. There was a difference in overall scores from admission to discharge and

this difference was statistically significant (See Table 3, p. 101). This finding supported rejecting the null hypothesis.

These findings are consistent with previous research on effectiveness of IOP/PHP treatment outcomes. In a study measuring outcomes using the BASIS-32 in a partial hospital setting, Jensen (2001), found statistically significant overall improvement in symptoms and functioning scores (subscales were not measured in the Jensen (2001) study, just overall scores from admission to discharge).

BASIS-32 Subscale Results

Research questions 2-4 of this study examined if positive changes occurred in behavioral and emotional functioning, based on the subscale scores from the BASIS-32. H_o = Adults in a PHP/IOP program that utilizes both traditional and expressive group counseling would demonstrate no improvement in symptoms as measured by scores of subscales 1 (relation to self and others), 2 (daily living and role functioning), and 3 (depression and anxiety) on the BASIS-32. Analyses of the pre and post-test of the BASIS-32 subscales scores with a paired *t*-test were completed. This finding supported rejecting the null hypothesis, in that there was a statistically significant difference between the pre- and post-administrations of the BASIS-32 for Subscales 1, 2, and 3 as there was improvement in symptoms and level of functioning in the post-treatment condition.

Research questions 5 and 6 of this study examined if positive changes occurred in impulsive and addictive behaviors (Subscale 4 of the BASIS-32) and symptoms of psychosis (Subscale 5 of the BASIS-32). The assumption of normality was violated for Subscales 4 and 5. Although this could be explained by the fact that legitimate outliers

were not eliminated. The pre- and post-results from these latter two subscales should be interpreted with caution, nevertheless, they still demonstrated a statistically significant difference and reject the null hypothesis.

Similar to the findings of the current study, Eisen, et al., (1997), using the BASIS-32, reported that participants scores were statistically significant from admission to discharge on Subscales 1, 2, and 3 (and scores at intake were in the "moderate difficulty" range and discharge scores improved to "little difficulty" range), however, Subscales 4 and 5 indicated that there was little difficulty for participants at the time of intake. This suggests that the areas measured in subscales four and five are less common in the PHP/IOP population compared to the areas measured in the first three subscales. The finding also suggests that the population sampled do not typically represent participants who are more likely to have psychosis or impulsive/addictive behaviors (Eisen, Wilcox, et al., 1997). The findings that are consistent with prior studies (Eisen, et al., 1997, Granello, et al., 1999, Jensen, 2001) is an important contribution that the current adds to the literature.

Patient Satisfaction

The seventh research question of the current study was to determine if the level of patient satisfaction of this program of study exceeded the national average. *Patient satisfaction* was previously operationalized based on the ratings of satisfaction from the 13-item Perception of Care survey (1=poor, 2=fair, 3=good, 4=very good, 5=excellent; AABH, 2020). The mean score for the year 2013 was 4.55, which indicates a rating of very good satisfaction (AABH, 2020). This was compared to the national average score of 4.36, which is also indicative of very good satisfaction, however, the results from the

present population sample indicates a marginally higher rating of very good satisfaction. The mean score for the year 2014 was 4.33, indicative of very good satisfaction, which was marginally below the national average of 4.38. The mean score of 4.45 for the year 2015 indicated a rating of very good satisfaction, which was compared to the national average score of 4.36, which is also indicative of very good satisfaction, however, the results from the present population sample indicates a marginally higher rating of very good satisfaction. The Perception of Care scores of the PHP/IOP of study, compared to the National Average (United States), demonstrated marginal differences for all three years.

Studies are limited on patient satisfaction and none were found to discuss the outcomes of the Perception of Care to measure patient satisfaction. Despite this, there were other studies that did examine satisfaction, using other measures. To recap, one study suggested that patient satisfaction contributed to treatment follow through and adherence and that patients who had higher satisfaction would benefit more from treatment than those who were less satisfied with their care (Priebe & Miglietta, 2019). Many assessments measure patient satisfaction in mental health care. An extensive literature review revealed that the Client Satisfaction Questionnaire, the Client Assessment of Treatment Scale, the Verona Service Satisfaction Scale, and the Self-Rating Patient Satisfaction Scale were determined to provide the most useful results (Priebe & Miglietta, 2019). Priebe & Miglietta (2019) also determined that:

> a number of socio-demographic characteristics such as gender, ethnicity, socio-economic and marital status have been suggested as determinants of satisfaction

> with care, but the associations are usually weak and the findings across studies are inconsistent. More substantial correlations have been found with clinical characteristics and patient reported outcomes, such as subjective quality of life. Patients with higher symptom levels, especially more depressive symptoms, with personality disorders and with lower subjective quality of life tend to express less satisfaction with their care. (p. 31)

In another study measuring patient satisfaction, Fortin, et al. (2018) utilized a conceptual framework based on:

> Andersen's behavioral model, comprising predisposing factors, enabling factors, and needs; socio-demographic, clinical, needs-related, service-use, and quality-of-life variables were integrated into the model. Using adjusted multiple linear regression models, the results were as follows: the mean score on patient satisfaction for primary and specialized care was approximately 4 (range: 3.67–5.0). Results revealed a high level of patient satisfaction with each type of care, with significant variables related to continuity of care, case management, and needs. The study suggested the critical importance of addressing patient needs comprehensively, and of establishing long-term, individual recovery plans that promote patient satisfaction. Collaboration between relatives of patients and professionals in patient treatment is closely related to satisfaction with primary care. (pp. 108, 111-112).

In studies done by Jensen (2001) and Granello, et al. (1999) both determined that patients were highly satisfied with their treatment and outcomes.

Implications

The results of this study are beneficial to various stakeholders, including counselors, the medical community, counselor supervisors, counselor educators, current and potential persons in PHP or IOP and their supports, payer sources, and AABH, among others, to further support PHP and IOP as a valid and necessary form of treatment to reduce relapse, prevent hospitalization, reduce costs, and improve the overall well-being of patients with acute mental health disorders.

Community Mental, Physical, and Behavioral Health Providers and Supervisors

It is consistently noted in the literature existing treatment approaches fail to adequately address the global crisis of mental health care (Lake & Turner, 2017; Kessler, 2011; Wise, 2003; Wise, 2010, World Health Organization, 2018). According to the results of this study, patients in a single IOP/PHP program reported that the services they received (between 2013-2015) were "very good to excellent" and their symptoms and level of functioning in multiple areas improved at the time of discharge compared to when they entered the program. The findings of this study can be used to inform community mental, physical, and behavioral health providers about the importance of PHP/IOP's. Additionally, the impact these programs can have on improving patient outcomes, reducing costs, allowing patients to participate in intensive programs and return home at the end of the treatment day. Furthermore, to focus on practicing skills learned in their natural environments and to build into their daily routines are all critical to the solution of addresses the crisis of mental health care. Additionally, psychiatric consultation and care while in the program can assist with increased medication compliance and improved monitoring and could likely increase the

chances of continued success with ongoing providers in the future. It is also well documented that the types of groups offered in the program studied are aligned with evidence-based practices (ASGW, 2000; Chien, et al., 2012; Gladding, 2016; Gordon & Kenny, 2018; Lukens & McFarlane, 2004; Pharoah, et al., 2010; Solomon, et al., 1996; Yalom, 1995). The results of the study support the effectiveness of the specific IOP/PHP treatment protocols offered to patients at the study site during 2013-2015. In my opinion, if this level of care continues to disappear in many parts of the United States, it could lead to decompensation on the part of clients and potentially higher numbers of visits to emergency departments with inpatient stays.

Providers in all settings should be prepared to work with patients/clients who may need higher levels of care, may require hospitalization without an intermediate level of care to help prevent the escalation of their symptoms potentially leading to mental health crises for patients. Counselors should also be advocates of intermediate levels of care and understand the protocols and standards to avoid closures to these vital programs, particularly given the effectiveness demonstrated in this study. The need for IOP/PHP programs is clear given that depression is the leading cause of disability in the United State for those aged 15-44, with annual losses in productivity from thirty to fifty million dollars (Kessler, 2011). However, many counselors do not receive adequate education and training to address higher levels of care, such as PHP and IOP. Clinical supervision is the foundation of quality assurance and improvement (Bernard & Goodyear, 2014) and effective clinical supervision is a necessary and relevant strategy to prepare counselors to address these issues and to assist clients in getting the appropriate level of care to address their acute symptomology.

Counselor Educators

In addition to benefiting counselors and other mental and behavioral health treatment providers, the results of this study have relevance for counselor educators. Counselor educators may incorporate the findings of this study to inform their teaching and research. As it relates to teaching, counselor educators are tasked with training the counselors who will work with clients that may require a higher level of mental health treatment, to help them avoid inpatient hospitalization, and remain in their communities whenever possible. Counselor educators who are informed of the various levels of care for mental health can better prepare counselors-in-training who plan to work with clients with acute symptomology that are expected to benefit and improve from participating in PHP or IOP, particularly clients presenting to treatment for concerns related to depression and anxiety with their symptoms impacting multiple areas of their life.

Counselor educators can also reinforce that while trained and licensed counselors are encouraged to use creative arts and expressive therapy approaches from time to time, ethically, art therapy should be practiced by those that have a master's degree in art therapy from institutions of higher education recognized by regional accreditation bodies approved by the Department of Education (American Art Therapy Association, 2015). Those art therapy professionals have met the "requirements [that] serve to protect the public and ensure that only those who are fully qualified to practice the specialized profession of art therapy are recognized and recognizable by use of the title, "art therapist" (American Art Therapy Association, 2015). Trained art therapists:

> Uniquely draw from multiple theoretical approaches in their understanding, design, and implementation of treatment. Art Therapists understand the science of imagery and the therapeutic potentials of color, texture, and various art media and how these affect a wide range of potential clients and personalities. Rigorous clinical training in working with individuals, families, groups, and communities prepare Art Therapists to make parallel assessments of clients' general psychological disposition and how art as a process is likely to moderate conditions and corresponding behavior. Recognizing the ability of art and artmaking to reveal thoughts and feelings, and knowledge and skill in safely managing the reactions they evoke, are competencies that define the Art Therapy profession (American Art Therapy Association, 2016, p. 2).

In the site studied, there was a clinician that held both a Master's degree in Art Therapy and in Counseling.

Current and Prospective Patients or Clients and their Supports

This research is also relevant to current and prospective persons admitted to a PHP or IOP. Awareness of PHP or IOP and its availability could directly impact the psychological and physical well-being of a person in need and their support network. PHP and IOP's also provide near immediate access to psychiatric care to address medications. This is important because in some areas, there are waiting lists for months to receive psychiatric care. Many patients in IOP/PHP may begin to feel improvement in a much shorter period compared to outpatient treatment, due to the intensity of treatment and interventions. In addition, PHP and IOP can help prevent hospitalization, but can also facilitate a hospitalization much more quickly if it is needed. Additionally, this level

of care is covered by most insurance companies and most patients that qualify for time off under the Family Medical Leave Act or Short-Term Disability can attend programs while they are off work. In addition, many PHP and IOP programs focus on relapse prevention and finding ways to recognize symptoms and increase management of these symptoms. These elements often bring a sense of relief to patients and families.

Payer Sources

Many managed care entities are invested in finding ways to lower costs to the company, but also to lowering the out of pocket costs to the insured. PHP and IOP are cost effective, however, they provide so many additional benefits. The results of this study can help demonstrate to payer sources that this is an effective mode of treatment, based on the results of treatment outcomes, the use of evidenced-based practices, and the level of patient satisfaction over a three-year period. In addition, when PHP and IOP programs are invested in organizations such as AABH, they increase their knowledge of standards and oversight, which in turn, supports the continued funding of these programs and prevents them from being shuttered.

Limitations of the Study

There are limitations to consider in this study. Limitations of effectiveness studies, in general, create limited internal validity and do not always allow for clinical comparisons (Moller, 2011; Waltman, 2018). The archived data studied was from a period of three years (2013-2015) and is five to eight years old and may not reflect current population samples. In addition, a comprehensive view (objective and subjective) may be limited by qualitative and mixed methods approaches not explored, due to time intensiveness and available resources. Using only one instrument to measure

participant symptoms at admission and at discharge may also not allow for a comprehensive review of participant progress, however, this is consistent with the practice at the PHP site providing access to the archived data.

The population studied was also largely homogeneous regarding race, limiting a diverse perspective on experiences in the program and outcomes. This could impact race as a dependent variable to participant satisfaction in the program and clinical outcomes. Additionally, generalizability may be narrowed to participants attending a combined PHP/IOP versus programs that are separated and may track outcomes after discharge from each program, racially homogeneous areas, presence of gender imbalance, and small program sizes (ten or less participants at a time). Additionally, while the Perception of Care surveys were administered to all 171 participants from the study, the national average statistics do not track demographics, which is a limitation to compare group responses. Despite the limitations, however, the researcher is hopeful the findings of this study are applicable to or found useful by peers and stakeholders alike.

Recommendations for Future Research

Future research in this area is recommended. One suggestion is to choose participants or data that is more recent to help reflect current trends and to study and more demographically representative sample. Additionally, with regard to sexual orientation and gender identity, utilizing more inclusive choices when collecting demographic data would increase diverse perspectives within the sample population.

Another suggestion for future research includes examining possible relationships among the variables included in this study. Following the design of Granello, et al. (1999) by using two-way ANOVA's and Post hoc Tukey tests to determine which

groups differed significantly at admission and discharge would bring a wealth of information to possibly help with predictors of those groups that fared better or worse from the program and treatment interventions.

With regard to patient satisfaction, there was no way to determine the number of participants in the national average when comparing it to the population sample since the national average data was compiled outside of the site being studied (whereas, all the other data was compiled by the site studied). In addition, it is recommended that an additional instrument of measurement be used. The Perception of Care survey, while sanctioned by the AABH, has limited literature discussing its psychometric properties. The Client Satisfaction Questionnaire-8 (CSQ-8) may be an alternative or additional instrument for future studies.

Conclusion

The present study investigated if adults in a combined partial hospital and intensive outpatient program that utilizes both traditional and expressive group counseling showed a decrease in severity of mental health symptoms and an increase in functioning between admission and discharge. In addition, examination of changes in behavioral and emotional functioning occur based on the analysis of subscales from the outcome measure (BASIS-32). Lastly, the level of patient satisfaction was studied and compared to the national average during a three-year period.

The results of this study, have several implications for various stakeholders, including counselors, the medical community, counselor supervisors, counselor educators, current and potential persons in PHP or IOP and their supports, payer sources, and AABH, among others, to further support PHP and IOP as a valid and necessary form

of treatment to reduce relapse, prevent hospitalization, reduce costs, and improve the overall well-being of patients with acute mental health disorders.

The findings, implications, and limitations of this study give direction to future research of partial hospital and intensive outpatient programs. Continued light needs to be shined on the effectiveness of PHP and IOP, and on the use of expressive and traditional group counseling approaches at this level of care.

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Appendix A

Group Schedule

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:30	Community Meeting	Community Meeting	Community Meeting	Community Meeting	Community Meeting
9:00	Weekly Goals	Self-Esteem	Reflective Writing	Art Therapy	Art Therapy
10:00	INDIVIDUAL THERAPY or PSYCHIATRY APPOINT-MENT	CASE REVIEW	INDIVIDUAL THERAPY or PSYCHIATRY AP-POINTMENT	INDIVIDUAL THERAPY or PSYCHIATRY AP-POINTMENT	10:00-11:00 Weekend Planning
11:00	Group Therapy	Group Therapy	Group Therapy	Group Therapy	Group Therapy
12:00-	LUNCH	LUNCH	LUNCH	LUNCH	12:00-12:30 LUNCH
1:00	Personal Recovery	Art Therapy I	Special Topics	Emotion Management	12:30 Creative Arts
2:00-3:00	Creative Arts	Art Therapy II	Assertiveness Skills	Stress Management	*The day will end at 1:30 on Fridays (unless you are sched-uled for an individual session at 1:30)*

Appendix B

ORIENTATION TO BEING IN A THERAPY GROUP

(Example of an Orientation to Being in a Therapy Group handout utilized at the study site).

Group Therapy provides a place for you to address the issues that are of concern to you, identify with others, offer and receive help and feedback from others, and examine patterns that are interfering with your personal growth.

If you are like most people, you may have some apprehensions about going to a therapy group. Concerns such as "What will the other people be like?" and "Am I capable of opening up to complete strangers?" are commonplace and are indicative of a very normal kind of anxiety. In fact, working through this very anxiety provides one of the many benefits that group has to offer.

Regardless of the emphasis, size, or makeup of your group, it is safe to say that the more you invest, the more you will benefit. In most therapy groups, one or two therapists are there to help facilitate interaction, discussion, and attention to the interpersonal processes

that occur. They are also there to help maintain an environment of safety and a focus on growth.

HOW TO GET THE MOST OUT OF A THERAPY GROUP

A good group therapy experience has much to offer to each person who participates. These are just a few suggestions to keep in mind as you begin your group experience:

- **Suspend judgment:** You may feel anxious about or impatient with your group as you start out. Just like individual therapy, group work takes time. Try to delay making judgments about the value of group; this adjustment period is very normal and part of the process. Commit to attending at least 4-6 group sessions before trying to determine the value of group for you
- **Start from where you are;** not where you think others want you to be. This is your chance to be yourself, to share the things that you think and feel and experience that you often keep to yourself. Change begins with whatever you feel free to disclose
- **Attend consistently:** Successful groups depend on a commitment from each member of the group, which means attending each session, arriving on time, and making an effort to participate in a meaningful way. Remember, in group therapy you are not only there for you

- **Think out loud:** Try to put words to the reactions you have to people/topics in the group and share these thoughts out loud, rather than censoring and silencing, as we often do in interpersonal interactions
- **Focus on the "here and now":** This is a phrase you may hear used by group facilitators or other members. It essentially means a focus on actual, lived experiences that you and the group are having in the session. It is appropriate to share your stories, but a group that just stays at the level of what is occurring/has occurred in the outside lives of its participants misses out on a very important, powerful dimension. Share what you are feeling and thinking about being in group, reactions you are having, what you feel towards others. This may feel scary at times; that is okay. Try to push yourself to do it anyway
- **Experiment with new behaviors:** Try new things out. Think of a therapy group as partly a social lab of sorts. If there are ideal ways you would like to interact, but rarely do, group is a great place to try them out and ask for feedback
- **Offer support and understanding before advice:** You may often be tempted to give advice and help "fix" the problems that others share. Often this comes from a place of empathy and compassion. In group, try to share that compassion and understanding first and foremost
- **Give and receive feedback:** One of the best things group has to offer is the advantage of getting input from several people instead of just one therapist. Take advantage of this! When you receive feedback, try to remain open and non-defensive. When you offer feedback, try to be specific, direct, and honest. This

aspect of group isn't always easy, but is one of its most powerful and growth inducing features

- **Be spontaneous:** Too often we mull over, think about, choose careful language, wait too long, try to be polite, or wait our turn to speak and react. This may water down or negate our freshness, sparkle or genuineness. Try to let ideas, thoughts, and feelings spill out and over, and trust that they will convey the true you. You are not expected no should you feel pressured to have everything figured out before you express yourself. Be mindful of censored expression and set goals to specifically share these things
- **Remember, this is time limited:** This is a treatment group program that is time limited. Identify what your group therapy goals (treatment plan goals) are: what would you most like to change? What can I ask of the group to help me with these goals? Please consider the fact that your time in the program is limited as you attend groups: choose the content that will be most helpful in meeting your treatment goals. Not waiting until the last minute to discuss important things could allow for a more successful outcome and experience.
- **Learning does not stop after the treatment day:** What you learn in group does not stop when you leave group. It is likely that you will find that the most growth happens when you spend time between sessions thinking about yourself, trying new behaviors, reflecting on what you are learning, reassessing your goals and paying attention to your feelings and reactions. Continue to think about what

occurred in group and outside of group. This is a time to personally reflect, practice, and notice the patterns in other relationships

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