The Emotion Identification Group

(awareness, communication, task group application)

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Emotion identification is an individual's ability to be aware of affective responses that occur during varied daily interactions. Through a review of the literature, how patients often seem unclear about the relevance of “doing” therapy to “talking/feeling” therapy is documented, and then an attempt is made to show how the occupational therapy emotion identification group can reinforce the patients' real-life connection between doing, talking, or feeling.

The basic premises formulated for establishing a method to promote emotion identification, the group format that incorporates this method, and patient responses to the method are presented.

How occupational therapy interfaces with Gestalt therapy and therapeutic community philosophies is shown and methods are described to apply the Gestalt process of one's getting in touch with and taking ownership for both needs and feelings in the emotion identification group and in occupational therapy task groups.

Interrelated Therapy Philosophies

The emotion identification group, the subject of this paper, has been a treatment used for 3 years by the occupational therapy staff on the psychiatric/alcoholism unit at Lorain Community Hospital, a general medicine hospital. Emotion identification is an individual's awareness of affective responses that occur in himself or herself during daily participation in varied object interactions.

Dunning states that “occupational therapists know by doing . . . . (1, p 22) Occupational therapists encourage the client to health by fostering his involvement in activity and developing physical, social and task competencies . . . by active practice and engagement with materials, tools and other persons.” (1, p 23)

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"Emotion identification concerns an individual's ability to be aware of affective responses . . . ."

However, Barton and Scheer assessed attitudes of patients toward an activity program and found that patients frequently did not agree that an "activity program offers a way of achieving better understanding of emotional difficulties." (2, p. 287) Patients did not seem able "to abstract life themes from the activity program." (2, p. 287) Barton and Scheer alerted the staff to the results of their assessment so that patients could become more informed "about the usefulness of the activities . . . to clarify their understanding of the activities." (2, p. 287)

Fidler and Fidler discuss how "middle class values place great significance on verbal skills." (3, p. 308) "... These (middle-class patients) are most frequently the clients who disdain activity programs and view action and doing as irrelevant to their needs, problems or life style." (3, p. 308) On the other hand, the Fidlers cite another group of persons encountered in broadly based community mental health programs "whose culture and learning experiences place a priority on action. These persons most frequently view talking as oblique to their needs, problems and life style." (3, p. 308)

The emotion identification group is a communication forum. Among various communication group tools described in psychiatric occupational therapy literature are puppetry to facilitate role play exercises (4), magazine picture collages (5), and art (6) to serve as projective media, and poetry as a group project to channel patient expression (7). As a communication group, the emotion identification format detailed in this paper uses adapted forms of the above modalities.

For example, while we did not use puppetry to enact role plays portrayed by Schuman, Marcus and Neese (4), our staff wrote group role plays and excerpted short scenes from published plays to help patients own up to degrees of the emotion being discussed. Producing and sharing a magazine picture collage promote discussion of an emotion, but we did not "score" the completed collages as did Lerner and Ross (5). In contrast to patients writing their own poetry as recorded by Rance and Price (7), the emotion identification group uses reading of published poetry selected for its relevance to a particular emotion.

The strategies mentioned are some of the tools chosen because of their capacities to evoke in patients a here-and-now awareness of emotion. "Here-and-now" awareness is a pivotal concept in Gestalt therapy. Gestalt therapy is one of the varied psychosocial treatment approaches unified by a "therapeutic community" philosophy on this hospital unit.

Gestalt therapy is based on a theory of "phenomenology" (8, p. 8) in which "primary interest (is) in the person as he unfolds his being in the world in the immediacy of the therapeutic encounter." (8, p. 9) The general intent of Gestalt therapy is "to create an atmosphere and attitude toward working in therapy that leads to greater awareness of the reality of oneself and how one interacts with others, and how one functions in the here-and-now." (9, p. 3)

Gestalt therapy theory interfaces with Maxman, Tucker, and LeBow's definition of therapeutic community as a place that duplicates in microcosm the larger community outside as well as the interpersonal and situational problems encountered there. Dealing with such problems in a therapeutic community occurs by necessity in the here-and-now. The major responsibility is "upon patients themselves to serve as primary change agents" (10, p. 58) by maximally using the "therapeutic potential of the entire staff." (10, p. 58)

References to Gestalt therapy are scarce in occupational therapy publications, but, in Activities Therapy, Mosey's suggested reading list includes Frederick Perls, a Gestalt therapy writer (11, p. 195). Mosey shows how psychiatric activity therapy groups capitalize on using here-and-now involvement to help patients deal with their own behavior, by "stopping whatever is going on in group (and) saying something like "I want to look at what's happening" (11, p. 190).

Fidler and Fidler stress the importance of dealing with feelings in the course of activity. "... Doing within this context is seen as a means for communicating feelings and ideas, expressing and clarifying individuality." (3, p. 306)

Purpose of Emotion Identification Group
Many Lorain Community Hospital psychiatric patients come from families of middle-income auto and...
steel assembly line workers. During joint patient/staff goal-planning group sessions, it was evident that patients could not extrapolate the life theme problems they addressed during group therapy for similar focus during occupational therapy.

The emotion identification group was an attempt to reinforce for the patient the link between doing and feeling in the occupational therapy process. The purpose of the emotion identification group is to teach members ways to sensitize themselves to their own emotional states and ways to desensitize themselves from fearing conflict-producing emotional states. The group, part of a total occupational therapy program, uses techniques including music, poetry, art, and psychodrama as illustrations to encourage patients to experience and to discuss a particular emotion each week. The group serves as a truism of reference for the patients’ participation in the occupational therapy task group, which prevails as the place where patients can experiment with getting in touch with and then expressing their emotions.

Structure of the Therapeutic Community Unit
This therapeutic community unit consists of 41 beds, three-quarters of which are for psychiatric patients and one-quarter for alcoholic patients. This paper concentrates on the use of the emotion identification group with the psychiatric patients only.

The average length of stay for psychiatric patients is 18 days. Diagnoses include schizophrenia, psychotic and neurotic depression, personality disorders, and manic-depressive psychoses. Patients span a wide age range. The 30 psychiatric patients are divided into three groups to work both in group therapy and in group occupational therapy.

Three multidisciplinary staff teams work with the three groups, and include social workers, nurses, occupational therapists (OTRs), an occupational therapy assistant (COTA), mental health workers, and a recreation therapist.

Each occupational therapy staff member, either the two OTRs or the supervised COTA, assumes primary responsibility for establishing occupational therapy treatment plans for one of the three psychiatric patient groups. Occupational therapy treatment plans are based in part on the interdisciplinary team treatment plan. They evolve after occupational therapy evaluations of communication skills, task performance, and activity of daily living skills. Treatment modalities encompass addressing skill deficiencies identified through the evaluations in activity groups, ADL groups, and in communication groups. The emotion identification group is one of the communication groups.

Emotion Identification: Basic Premises
Emotion identification is a skill that patients often must learn in the course of psychotherapy. During the emotion identification group experience, inpatients begin to look at the degrees of their emotional responses. Patients who can benefit from the therapeutic community may remain hospitalized longer than the average, brief 18 days. The goal is to prepare these patients to continue to work through identified problems as outpatients. Asking patients to look at their emotional responses often requires the therapist to “go through the process of suggesting possible emotions the patient may be experiencing... Suggestions are made tentatively allowing the patient to try to get at or to the level of his feelings.” (II, p 182)

The therapeutic community places responsibility for patient therapy on the physician-supervised multidisciplinary team. Staff members, together with the physician, actively treat patients. In this active role—of helping the patient with the process of being open to experiencing emotions—the staff must remain open to experiencing emotions without undue self- or group censorship. Staff members must examine their own degrees of comfort and discomfort when experiencing the spectrum of human emotions. They must remain aware that the diagnoses, in part, determine the rate patients will be able to take advantage of a therapeutic learning experience, and that diagnoses will influence the selection of defenses to be mobilized in reaction to the learning experience.

In establishing a method to promote emotion identification, the following premises were formulated: 1. that emotions are experienced in degrees ranging from apparent absence to mild, to moderate, to strong; 2. that these degrees are defined partly by the language the patient uses to interpret a personal experience to himself and then to others; 3. that using words in a general, nonspecific way to express a specific emotion actually may prevent one from even mildly experiencing an emotion that one has blocked and denied in the past; 4. that one may resist considering and attending to emotions that carry anxiety-producing associations; 5. that an experiential encounter with a particular emotion can in turn facilitate a meaningful learning encounter; 6. that interaction with another person is effective partly to
the extent that one is in touch with and accepting of his or her own wide range of feelings; 7. that emotion identification is a skill that can be developed and implemented in the occupational therapy task group setting.

Format for the Emotion Identification Group

Over the three years the group has been organized, the OT staff has developed a half-didactic, half-experiential format to help a patient gain contact with degrees of each emotion. Once a week, most of the 30 psychiatric patients on the unit meet for the 1/2 hour group session, except for the most overtly psychotic patients. The group usually contains about 24 members. The demands of the patients' daily multifaceted schedule dictate combining the three psychiatric patient groups for the single emotion identification session. The combination group approach gives all patients exposure to people who are dealing with life themes that a single small group may miss. However, some patients may feel more comfortable interacting in a smaller emotion identification group. One OT staff member leads while the others assist and observe how patients tolerate and process the session.

The group proceeds as follows:

1. Members introduce themselves and the leader states the purpose of the group. “Every week we look at a different specific human emotion. These emotions include sadness, shyness, loneliness, anger, love, inferiority, anticipation, kindness, fear, jealousy and happiness. We gain acquaintance with a variety of words we can use to indicate ranges of emotions so that we can tune into our own experiences and so we can let another person know, in words, what we are feeling.” 2. The leader encourages patients to brainstorm for “... words we might use to communicate an emotion with someone.” If a member suggests an inappropriate word, the group decides whether or not such a word actually expresses the emotion. After all words are listed on a chalkboard, the group determines words that seem to portray the emotion in mild, moderate, or strong degrees. Debate and discussion follow some suggestions. 3. The leader distributes to each patient a word list (compiled from the thesaurus) to supplement words suggested by patients. The purpose is to expand the working vocabulary of the group, as well as to share colloquial expressions that often explain how an emotion sometimes is expressed somatically even before a cognitive awareness of the emotion appears. Patients can learn that by becoming aware of their own somatizations, they can receive cues about their emotional state. For example, the group considers such phrases as “hot under the collar,” “feeling warmly toward,” “feeling icy toward,” feeling on “pins and needles,” or feeling “breathless expectation.” At times, dictionary definitions clarify some of the words. A patient volunteers to read the word list aloud.

4. The leader elicits group members’ ideas about life situations that provoke differing levels of the specific emotion. These ideas are written on the chalkboard.

5. To introduce the next segment of the session in which the group participates in reading poems (handouts) and in listening to music related to the emotion, the leader explains, “Authors and musicians experience this same emotion. They express what they feel in their own ways. By considering how these artists feel we know we’re not alone in experiencing our emotions, and their works may make it easier for us to get in touch with what we are experiencing.” A volunteer reads the poems, and then members discuss their reactions.

To accompany the taped recordings, lyric handouts are provided so that members can see the words while they listen to each song. Some patients sing along to the music. During discussions comparing the music to the meaning of the lyrics, patients may appreciate how music and words are not always, and how similarly, their own words do not always express the emotion they are really experiencing.

6. The leader introduces a structured group activity that moves the patient closer to experiencing and/or expressing ownership of some grade of the specific emotion under discussion. Acting a scene from a play, painting the way grades of an emotion feel, role-playing different vignettes depicting situations that provoke feelings such as inferiority, making small individual magazine picture collages as a projective medium, wedging modeling clay by throwing it on the floor, and listening exercises are group activities employed to promote individual awareness of emotion.

This experiential Gestalt-oriented, “here-and-now” format helps the occupational therapy staff and patients relate each week to pertinent emotional themes as the needs...
Observations about the Group Process

Patients' responses to the leader's spoken explanations about the purpose of the group and to the group format fall into several categories.

1. Emotions are experienced in degrees: Although the concept of "grading" is not unique to occupational therapy, it is a cornerstone in its treatment philosophy, for example, using graded activities to help the patient progress by increments toward a hoped-for, long-range goal. The idea of graded emotional experience seems attractive and reassuring to patients in that it seems to promote a sense of being able to control the amount of what patients can choose to experience, or to admit that they experience, in accordance with how supported they may feel. Graded emotional experience as a concept is consistent with the Gestalt therapy approach of "small units of therapy." (12, p. 7)

2. Using emotion-identification words in a too-general way may prevent patients from experiencing a conflict-associated emotion: There is a human tendency to use a single word, such as angry, to cover the entire range of anger-related feelings prompted by having been hurt or by frustration. Some patients who block all awareness of "anger" when in general terms are comforted by the idea that one can feel irritated, annoyed, irritated, put-out, or imposed upon before the emotion escalates to feeling incensed or exasperated, or in a stew, or in a huff. And patients seem to accept experiencing these levels of anger before seeing red, feeling livid, feeling boiling or foaming, or feeling violent, savage, or exploding with anger.

The process of sensitizing patients to experiencing an emotion is linked to the process of desensitizing them to the fears they associate with experiencing all grades of the emotion. Patients are encouraged to use words to help them exchange acting out for verbalizing, to productively fantasize what they feel, to understand some of their somatizations, and to gain emotional awareness.

"Awareness refers to the experience and description of current ongoing conditions reflecting the person's sensation and perception. . . . Awareness differs from insight through its continuing nature as an ongoing process, readily available, at all times rather than sporadic illuminations one experiences in special moments. . . . Focusing on one's awareness keeps one absorbed in the present situation." (12, p. 5)

"The emotion can be experienced . . . beginning at relatively comfortable low levels . . . ."

3. Patients may experience resistance to considering and attending to anxiety and guilt-producing emotions: During the group sessions, fidgeting or silence, subgroup laughter, or joking, or sarcasm; introduction of off-the-track subjects, or asking to leave the session are frequent behaviors. To a group leader whose "goal" is to look at an emotion, such occurrences are disconcerting. In such situations the staff has found it helpful to focus on the group's difficulty in attending to painful feelings that members usually hide or try to avoid. Once the group confirms that it is resisting the discussion, it is more willing to return to the task and the emotional subject.

4. Experiential encounter with a particular emotion facilitates a meaningful learning encounter: When the leader introduces the group activities some patients show increased resistive behavior and cease to participate. Patients who participate in the activity have often received support to do so from their small group therapy sessions and/or from the therapeutic community meetings. These meetings establish intense group cohesion, which is helpful considering the short hospitalization time available to the patients. In these sessions, patients become accustomed to the sanction of "working on themselves" and learn to expect continued problematic behavior themes during the emotion identification group.

During the group activity, peer group support is especially important for those experiential encounters involving spontaneous media such as role playing, or one-on-one dialogues spoken before the large groups. Comparatively, patients seem less anxious and less in need of peer support when activities involve impersonal or projective media.

At the end of these experiential encounters, patients show different degrees of resolution with their emotions. Some verbalize enthusiastically about an activity that has allowed them to experience an emotion they usually would have consciously or unconsciously avoided. Such patients go on to respond to...
other events of the day with no further consequences related to their experience during the emotion identification group. Other patients discover that the activity increases their anxiety about a particular emotion. They need immediate followup with the group leader or with another staff member to discuss feelings that have come to awareness.

7. Effective interaction with another person is due partly to the degree that one is in touch with and accepting of his or her own range of feelings: Patients often indicate interest, verbally and nonverbally, when the group leader mentions one purpose of the emotion identification group as “learning to communicate feelings with another person.” More verbal patients state that “communicating” is a goal they want to reach. Yet, paradoxically, after participating in the group activity designed to elicit feelings, patients often discover that a particular emotion is difficult to admit to themselves.

For example, during an activity that involves telling another person “what you admire and are even ‘a little jealous’ of in that person,” patients experience an attempt to overcome their own self-condemnation of feeling jealousy in the first place, and then self-condemnation in sharing this feeling—that they themselves “frown upon” in another person. Patients seem pleased to know that the group priority is to settle with one’s self and seeing what “lives there.” It requires the patient to “focus on the sensory data, feelings and reactions to experiences from within himself and from his environment.” (9, p.5)

8. Emotion identification is a skill that can be developed and implemented in occupational therapy task groups: The Gestalt “experiment” (12, p.7) of being in the moment’s experience and looking at it is readily available to the patient during the graded format of the emotion-identification group; that is, group activities range from requiring “objective involvement” during a discussion about expressive language, to a moderately subjective experience of attending to the emotional content of someone else’s poems and music, to the more intensely subjective participation at the end of the group in one’s own activity.

In my experience, patients tend to isolate the group from their other occupational therapy program, and seem surprised to discover that emotion identification can be used to derive meaning from their participation in the occupational therapy task groups. For more verbal and intense patients who are able to look at here-and-now moments, the task groups offer a unique “real life” experience. Involvement with practical tasks presents patients with what they often find to be a difficult here-and-now experience.

Descriptions follow of patients’ reactions to using their OT task group involvement in order to learn more about 1. getting in touch with one’s self, and 2. becoming more comfortable with owning the feelings of which they have become aware. These two examples illustrate use of the Gestalt experiment (12, p.7).

First Directed-Behavior Experiment. In this experiment the patient recognizes concrete needs as a first step in recognizing feelings. This process of getting in touch with a utilitarian need gives the patient practice in “backing off into himself and seeing what ‘lives there.’ ” It requires the patient to “focus on the sensory data, feelings and reactions to experiences from within himself and from his environment.” (9, p.5)

It takes many repetitions for patients to become comfortable with the process of getting in touch with a concrete need and then stating it in a clear, direct way to the therapist during the OT task group.

To illustrate the process: 1. The patients begin by listening to themselves. “I’m ready for the next step in my work. I need something. What do I need?” 2. The patients get in touch with themselves and their needs, and subsequently become aware of what they need: “I need a hammer.” 3. The patient often verbalizes needs in an entertaining way, as though still a child and the therapist a parental authority figure. The patient often seems unable to offer a clear direct statement and taking ownership for the need, by saying “I would like you to get me a hammer.”

When participating in the above directed-behavior experiment, patients often report feeling as though they are being aggressive when they take ownership and use the personal pronoun “I,” followed by the verb “want,” which will impinge on the object “you” (therapist) from whom the patient is requesting a need. Patients begin to look at how their choices of words can both make them feel and convey how they feel. Patients also begin to experience how “First person statements enhance awareness of . . . aspects of what is being said.” (9, p.6)

Second Directed-Behavior Experiment. This exercise involves getting in touch with a feeling part of oneself rather than with a need. It is more difficult for patients than the first exercise. In the OT task group a patient may appear as an adult who does not admit feeling anger, for instance, when frustrated with performing a here-and-now activity. The therapist expects this patient to perform a here-and-now activity. The therapist expects this patient to perform a here-and-now activity.
the therapist suggests that he seems to be experiencing some degree of anger at a work problem.

Such patients have learned early in life that becoming aware of and expressing emotions is associated with unrewarding consequences, perhaps punishment. Experiencing the emotion has become associated with risking danger and feeling guilty.

In Gestalt therapy, "taking a risk refers to a patient’s fears . . . that if he reveals himself he invites catastrophic reaction." (9, 998) In the author’s experience, when a patient encounters an emotion-producing experience in the OT task group, the revelation of that emotion can be undertaken more readily, with an increased sense of safety in the patient, when the therapist helps the patient continue the work begun in the emotion identification group. That is, when the therapist reminds the patient that the emotion can be experienced in graded levels of intensity, beginning at relatively comfortable low levels, the patient more acceptably admits to owning a degree of the feeling. The amount of the emotion admitted is reflected in the language that the therapist guides the patient to use, so that he may admit owning a little "annoyance" or "irritation." Similarly, the patient can be guided to use graded language to interpret other emotions that he experiences during the task group.

Conclusion

Emotion identification, defined as an individual’s awareness of affective responses that occur during varied daily object interactions, has been discussed as a skill that occupational therapy can help patients develop.

The occupational therapy staff designed an emotion identification group curriculum that engenders a here-and-now opportunity to help patients sensitize themselves to experiencing grades of their own emotions. By conducting emotion identification as part of a total program, the occupational therapy staff prepares patients to pursue emotional awareness during their participation in the occupational therapy task group.

Further refinement of the emotion identification group would include assessing the degree patients perceive the relatedness between their work in the emotion identification group and in the task groups. A patient questionnaire to measure individual patient anxiety levels after each group session might also be developed.

An added benefit of the emotion identification group has been the occupational therapy staff’s application of this group to sharpening personal emotion identification awareness during task group sessions (13, pp 272-273). The emotion identification group premises and format may be relevant for use by occupational therapists in other settings.

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REFERENCES


RELATED READINGS

Kempf W: Principles of Gestalt Family Therapy, Salt Lake City: Desert Press, 1974