Emotional empathy and cognitive styles in psychodynamic group therapy: UAE experience

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Background
Practice of group therapy has been unexpectedly accepted against the presumption that patients could reject the idea of self-disclosure in the presence of strangers.
Objectives
The present study was designed to study group psychotherapy experience in the United Arab Emirates (UAE). The group cohesion process along the time of therapy was studied. A trial was also carried out to explore the impact of attending such groups on aspects of thinking described as cognitive styles as fears of failure and anger expression, as well as cognitive orientation of emotions and empathy.
Patients and methods
In the present case–control study, 80 patients (40 males and 40 females) between 19 and 45 years of age with different DSM-IV psychiatric diagnoses were recruited and subdivided into four groups. Each group included 20 patients – 20 males and 20 females allocated to attend group therapy [male group (MGp) and female group (FGp)], whereas the other 20 males and 20 females were allocated into comparative groups not attending group therapy [male comparative (MCm) and female comparative (FCm)]. All groups were further compared with frequency-matched healthy volunteers who served as control groups consisting of 20 males in the MCl group and 20 females in the FCl group. Sharing groups were subjected to clinical psychiatric examination and baseline psychometric assessment using Fear Of Failure (FOF1), Trait Meta Mood Scale (TMMS1), Arabic Anger Scale (AAS1), and Emotional Empathy Scale (EES1). Each patient in the male group (MGp) and the female group (FGp) attended at least 40 sessions in closed groups for 1 year. Group cohesion was assessed monthly using The Group Cohesiveness Scale (GCS) (1–12) for both groups. Psychometric re-evaluation at the end of 1 year was performed for all groups using the same tests – FOF2, TMMS2, AAS2, and EES2. All available scores were subjected to statistical analysis.
Results
Baseline readings showed statistically significant higher scores of FOF1 and AAS1 in patients compared with controls ($P<0.00001$) and lower scores of TMMS1 and EES1 ($P=0.0020$ for the three male groups and $P<0.00001$ for the three female groups). However, differences between groups of patients [(MGp vs. MCm) and (FGp vs. FCm)] were nonsignificant for FOF1 ($P=1$ and 0.28809), AAS1 ($P=1$ and 0.5186), TMMS1 ($P=0.6326$ and 0.6773), and EES1 ($P=0.7491$ and 1). In general, females showed more regular attendance during group sessions compared with males, but the difference was nonsignificant statistically. Patients' assessment of group cohesion generally increased along the 12 months as denoted by GCS scores. Patients attending group therapy demonstrated variable levels of improvements compared with other groups of patients not attending group therapy and compared with controls. FOF2 demonstrated definite improvement in the MGp compared with the MCm group ($P=0.0283$) and in the FGp compared with the FCm group ($P=0.0480$); however, improvement was beyond normality compared with control groups ($P<0.00001$). EES2 demonstrated definite improvement in the MGp compared with the MCm group ($P=0.01813$) and in the FGp compared with the FCm group ($P=0.038434$), and improvement reached normality compared with control groups (P is nonsignificant). All TMMS2 scores of patient groups increased on treatment regardless of attending group therapy or not. Improvement in males reached normal levels compared with controls ($P=0.1220$ for the three male groups), but not in female patients ($P=0.0021$ for FGp vs. FCl). However, FGp patients showed more improvement than the FCm group ($P=0.0044$). AAS2 demonstrated definite improvement in scores in all groups of

patients after treatment with no significant difference between the MGp and MCm group (P=0.6756) or between the FGp and FCm group (P=0.1903); however, improvement was beyond normality in comparison with control groups (P<0.00001).

Conclusion

Group therapy has been successfully accepted among UAE psychiatric patients, improving their fears about failure and empathy and to variable degree cognitive orientation of emotions but not anger expression.

Keywords:
cognitive styles, empathy, group cohesion, group therapy

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Introduction

Psychotherapy is the art of helping patients within a professional, structured setting, with the main goal of alleviating the suffering of patients and their families. Practice of group therapy has been unexpectedly accepted against the presumption that patients could reject the idea of self-disclosure in the presence of strangers (Rakhawy, 2001).Research on group therapy indicates that various dimensions of helpful relationship qualities (cohesion, climate, empathy, alliance) are associated with outcome (Ryum *et al.*, 2009).Cohesion is a strong determinant for positive group outcome as it fosters therapeutic factors to operate (Yalom, 2005) and leads to a more productive group work with trust and acceptance, empathy and caring, intimacy, hope, catharsis expression, cognitive reconstruction, commitment to change, and feedback with both confrontation and self-disclosure abilities (Corey, 2012).

Early attempts of using group psychotherapy within the Arab culture started in Egypt in the 1970s mainly by Rakhawy and Shaalan (Haggag, 2001). Rakhawy's students are increasingly practising the Kasr El-Aini model of group psychotherapy for the last three decades both in Egypt and in Arab Gulf countries (Matar, 2014). The common rules that characterize such an approach include the 'here and now' and 'I – thou' rules (Rakhawy, 2001). To our knowledge, our psychiatric department in 'Sharjah Medical District Hospitals' is the only center to introduce this type of service (psychodynamic group psychotherapy) as part and parcel of psychiatric treatment all over the United Arab Emirates (UAE) (Matar, 2014). In the first trial, introducing the psychodynamic-oriented group therapy (2002–2003), members were very resistant to share and were even noncompliant, especially in male groups. Gradually, in the second trial (2005–2006), compliance and commitment increased. The culture of UAE with lesser population compared with Egypt makes people easily know each other personally or by family name. The culturally related traditions of dealing with some people as VIP (very important persons) in UAE has made some people very conservative, refusing to disclose and share their problems or even discontinue attendance for the fear of being known. In the early trial, one woman insisted to stay with her face covered throughout the sessions in the female group to avoid being known. The first male group was discontinued abruptly because of lack of attendance after a couple of months, whereas the second trial continued successfully up to the scheduled time (1 year). Sometime after the second season ended, some patients visiting the clinic for follow-up surprisingly asked for joining such group therapies. We planned to prepare for the third season where the current study was included. The aim of the present study was to explore the impact of attending group psychotherapy on empathy, cognitive orientation of emotions, as well as cognitive styles of fears of failure and anger expression – a unique experience of group therapy in UAE. The group cohesion process – as a parameter for positive group outcome – along the time of therapy was also assessed.

Patients and methods

Study design

A prospective, case–control, naturalistic study was performed in the outpatient clinics of the 'Psychiatric Department' in governmental general hospitals in 'Sharjah Medical District' in UAE, located in 'Sharjah Kuwaiti Hospital'.

Patients

All patients visiting outpatient clinics of the 'Psychiatric Department' in government general hospitals in 'Sharjah Medical District' for the first time from September to November 2007, fulfilling inclusion and exclusion criteria, were registered for further assessment. Patients were recruited into the study after regular treatment and follow-up every 2 weeks. Patients provided consent to share their problems while participating in the study. A total of

80 patients (40 males and 40 females) aged between 19 and 45 years with different DSM-IV psychiatric diagnoses were recruited. Apart from cognitive disorders, substance-related disorders and antisocial personality disorder patients, no other psychiatric diagnosis was excluded. Cognitive disorder patients were excluded to avoid communication difficulties during group sessions due to cognitive impairment. Substance-related disorders were not treated in our department and were referred to the specialized 'Sharjah Rehabilitation Centre for Addiction Treatment'. Antisocial personality disorder patients were excluded as they perform poorly in heteroge neous group sessions because of their difficulties in adherence to structure and inabilities to be committed to group standards (Sadock *et al.*, 2009). Patients inclu ded in the study attended their clinical follow-up sessions at least twice in 1 month before joining the study. This gave patients with active-phase psychotic symptoms, depressed patients, and manic patients some chance to be under pharmacological control before joining the group sessions (Sadock *et al.*, 2009). December 2007 served as the preparatory phase for recruiting patients to the study groups as well as for performing all psychometric assessments for baseline readings. Accordingly, the study was conducted during the period between 1 January and 31 December 2008, taking almost 12 months to complete. As not all patients agreed to join group psychotherapy, our naturalistic study allocated recruited patients into two groups on the basis of their consent to share their problems in group psychot herapy sessions. In addition, as a client-centered, culture-oriented clinic, two separate psychotherapy groups, each one with the same sex, were arranged. Therefore, patients giving consent to share their problems in group therapy were divided into two groups: 20 males in one group (MGp) and 20 females in the second group (FGp). Patients who did not provide consent for group therapy served as the comparative group: 20 males in the MCm group and 20 females in the FCm group. All patients were selected from Arabian nationalities, who could read and write Arabic fluently, able to undergo the needed assessments, and join the psychotherapy sessions running in Arabic language. Moreover, selected patients had to have at least primary or middle school education to assure average level of intelligence. Patients who were illiterate or had not completed their primary and middle school education were excluded. We also excluded those who refused to participate or withdraw during the interview. Patient groups were further compared with control groups, which included frequency-matched 40 healthy volunteers [20 males (MCl) and 20 females (FCl)] with Arabic background and no past or family history of psychiatric disorders. Control cases were selected from among employees in the Kuwaiti Hospital.

Ethical consideration

Ethics approval for the study was obtained from the Ethics Research Committee (ERC) of Sharjah Kuwaiti Hospital from where patients were selected. An informed consent was obtained from all patients, after being informed about the details of the study and about what they were asked to do. Patients were ensured about the confidentiality of information and that participation in the study was completely voluntary and they have the freedom to withdraw from the assessment at any time point.

Procedures

(1) The patients were assessed for registration and they completed the following:
   (a) Initial clinical psychiatric assessment of all 80 patients in their early stages of illness, which included psychiatric history form a reliable informant, mental status examination, and psychiatric diagnosis using DSM-IV (American Psychiatric Association, 1994). Control cases were clinically interviewed to exclude current or past history or family history of psychiatric illness.
   (b) Treatment plan matching with each case was introduced to patients, including the schedule of follow-up visits every 2 weeks – in the first month – followed by regular visits once a month.
   (c) Pharmacological treatment was prescribed for all patients according to individual case needs among his/her treatment plan.
   (d) Registered patients gave consent to share their problems during the study.
   (e) Being a naturalistic study, registered patients followed their treatment plans regularly as other patients attending the clinic monthly for assessment of treatment progress, repeating the mental state examination in each visit, and hence receiving prescribed medication accordingly.

(2) Baseline psychometric assessment was carried out for all six groups using the following:
   (a) *Fear of Failure Scale (FOF1):* An Arabic comparative test for specific phenomenon with no definite score to denote normal range; instead, scale items were divided into

four compartments to assess specific negative rationales that are usually related to one's negative thinking style of fear of failure. The four subcategories of the scale include lack of self-confidence, inferiority feelings, negative expectations about/of others, as well as negative perception of competition (Moawad and Mohamed, 2006).

(b) *Trait Meta Mood Scale (TMMS1)*: A translated Arabic form of the Scale – with permission – was used, which consisted of 30 positive and negative statements to assess cognitive orientation of emotions, and each statement had five choices (strongly agree, agree, not sure, disagree, strongly disagree). Answers were scored on a continuum from 1 to 5. The total scale ranged from 30 (lower emotional orientation) to 150 (higher emotional orientation). The scale has three subscales measuring attention to feelings, clarity of feelings, and tendency to mood repair. Therefore, there was no definite score to denote normal range but rather a descriptive assessment of having low/high orientation to emotions (Kafafy and El Dawash, 2006a).

(c) *Arabic Anger Scale (AAS1)*: This is a 40-item scale for anger expression and control; each item is scored on a 1–5 scale. The AAS cutoff score for normality range is 41–80, with further grading of severity as mild, moderate, and severe degrees (Kafafy and Al Nyal, 2000).

(d) *Emotional Empathy Scale (EES1)*: A translated Arabic form of the scale – with permission – was used, which consisted of 30 positive and negative statements to assess emotional empathy. Each statement has five choices (always, too much, sometimes, little, rare). Answers were scored on a continuum from 1 to 5. The total scale ranged from 30 (lower emotional empathy) to 150 (higher emotional empathy). The scale measured six areas: suffering, positive sharing, responsive crying, emotional attention, feel of others, and emotional contagion. Assessment described the tendency to have low/high emotional empathy with no definite score to denote normal range (Kafafy and El Dawash, 2006b).

(3) Each patient in the male group (MGp) and the female group (FGp) attended the psychodynamic psychotherapy session in a closed group of 20 patients at least for 40 sessions of 90 min once weekly for a year; long enough to allow for cohesion development and productivity of the group therapy (Corey *et al.*, 2007). Group cohesion was assessed monthly using GCS for both groups. GCS readings were numbered after months (1–12) for each group. GCQ-S (group climate questionnaire scoring) is a 12-item questionnaire developed by Mac Kenzie (1983) to assess group cohesion process thinking of a group as a whole. For each item, the client chooses the most appropriate heading that best describes the group during the determined four sessions from seven-dimensional describing headings [Not at all (0), A little bit (1), Somewhat (2), Moderately (3), Quite a bit (5), A great deal (6), Extremely (7)]. The scale has three subscales 'Engaged, Conflict, Avoiding'. *Engaged items* describe the positive working group atmosphere. *Conflict items* reflect anger and tension in the group. *Avoiding items* describe behaviors indicating avoidance of personal responsibility of group work by the members (Mac Kenzie, 1983).

(4) Psychometric re-evaluation at the end of 1 year was performed for all groups using the same tests – FOF2, TMMS2, AAS2 and EES2.

Statistical analysis

All available scores were subjected to statistical analysis. Data collected were reviewed, coded and analyzed using SPSS (Statistical Package for Social Science) version 11 (SPSS Inc., Chicago, Illinois, USA). Numerical data are presented as mean and SD values. Categorical data are presented as frequencies and percentages. Comparison between groups was carried out using the χ^2-test with correction for eventual small numbers; P values are presented, and the threshold of significance was fixed at the 5% level. Comparison between three groups was carried out using one-way analysis of variance and corresponding nonparametric tests to test whether the mean±SD of a variable differed among the three groups.

Results

Comparison of demographic data (Table 1) revealed that the six sharing groups had no statistically significant differences in age (P=0.999661), education (P=0.9740), marital status (P=0.997), and nationality (P=0.724). However, comparing occupation in the six groups showed statistically significant differences (P<0.0000001), but not among the four groups of patients (P=0.1174). Psychiatric diagnoses did not differ significantly in male and female patients (Tables 2 and 3,).

Table 1 Demographic information with respect to age, education, marital status, and nationality of all groups

Data	Male group (n=20) [n (%)]	Female group (n=20) [n (%)]	Males comparative (n=20) [n (%)]	Female comparative (n=20) [n (%)]	Male control (n=20) [n (%)]	Female control (n=20) [n (%)]	Statistics χ^2	*P*	Significance
Age (years)									
≤30	15 (75.00)	16 (80.00)	15 (75.00)	16 (80.00)	15 (75.00)	16 (80.00)	78.174	0.999	No
>30	5 (25.00)	4 (20.00)	5 (25.00)	4 (20.00)	5 (25.00)	4 (20.00)			
Mean±SD	26.7±7.24	26.2±6.52	26.65±7.2	26.2±7.11	26.6±7.34	26.2±6.98			
Education									
Mid school	9 (45.00)	10 (50.00)	8 (40.00)	8 (40.00)	8 (40.00)	8 (40.00)	3.276	0.974	No
Secondary school	6 (30.00)	6 (30.00)	5 (25.00)	8 (40.00)	8 (40.00)	8 (40.00)			
University	5 (25.00)	4 (20.00)	7 (35.00)	4 (20.00)	4 (20.00)	4 (20.00)			
Occupation									
None	9 (45.00)	9 (45.00)	9 (45.00)	7 (35.00)	0 (0.00)	0 (0.00)	69.045	<0.000	Yes
House wife	0 (0.00)	5 (25.00)	0 (0.00)	6 (30.00)	0 (0.00)	0 (0.00)			
Student	3 (15.00)	1 (5.00)	3 (15.00)	2 (10.00)	0 (0.00)	0 (0.00)			
Employer	8 (40.00)	5 (25.00)	8 (40.00)	5 (25.00)	20 (100.00)	20 (100.00)			
Marital status									
Single	8 (40.00)	8 (40.00)	8 (40.00)	6 (30.00)	8 (40.00)	7 (35.00)	1.878	0.997	No
Married	9 (45.00)	8 (40.00)	7 (35.00)	9 (45.00)	9 (45.00)	9 (45.00)			
Divorced	3 (15.00)	4 (20.00)	5 (25.00)	5 (25.00)	3 (15.00)	4 (20.00)			
Nationality									
UAE	16 (80.00)	14 (70.00)	13 (65.00)	13 (65.00)	16 (80.00)	12 (60.00)	25.024	0.724	No
Egypt	1 (5.00)	3 (15.00)	3 (15.00)	1 (5.00)	1 (5.00)	1 (5.00)			
Palestine	2 (10.00)	1 (5.00)	3 (15.00)	4 (20.00)	2 (10.00)	5 (25.00)			
Syrian	1 (5.00)	1 (5.00)	1 (5.00)	2 (10.00)	1 (5.00)	0 (0.00)			
Somalese	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (5.00)			
Moraco	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	1 (5.00)			
Lebanon	0 (0.00)	1 (5.00)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)			

Table 2 Distribution of psychiatric diagnoses among patients attending group therapy

Data	Male group (n=20) [n (%)]	Female group (n=20) [n (%)]	Statistics χ^2	*P*	Significance
Diagnosis (Axis I)					
Bipolar I depression	1 (5.00)	1 (5.00)	3.286447	0.915117	No
Bipolar I mania	2 (10.00)	3 (15.00)			
Delusional disorder	1 (5.00)	0 (0.00)			
Major depressive disorder	3 (15.00)	4 (20.00)			
Obsessive compulsive disorder	1 (5.00)	0 (0.00)			
Panic disorder	6 (30.00)	7 (35.00)			
Schizophrenia disorganized	1 (5.00)	2 (10.00)			
Schizophrenia paranoid	3 (15.00)	2 (10.00)			
Schizoaffective disorder	2 (10.00)	1 (5.00)			
Diagnosis (Axis II)					
Personality disorder (schizoid)	1 (5.00)	0 (0.00)	2.111111	0.549668	No
Personality disorder (obsessive)	1 (5.00)	0 (0.00)			
Personality disorder (paranoid)	1 (5.00)	1 (5.00)			
No diagnosis	17 (85.00)	19 (95.00)			

Psychometric baseline readings showed statistically significant higher scores of FOF1 and AAS1 in patient groups compared with control groups ($P<0.00001$) and lower scores of TMMS1 and EES1 ($P=0.0020$ in the three male groups shown in Table 4 and $P<0.00001$ for the three female groups shown in Table 5). However, differences between groups of patients [(MGp vs. MCm) and (FGp vs. FCm)] were nonsignificant for FOF1 ($P=1$ and 0.28809), AAS1 ($P=1$ and 0.5186), TMMS1

Table 3 Distribution of psychiatric diagnoses among patients in comparative groups

Data	Male comparative (n=20) [n (%)]	Female comparative (n=20) [n (%)]	Statistics		
			χ^2	*P*	Significance
Diagnosis (Axis I)					
Bipolar I depression	1 (5.00)	1 (5.00)	2.424242	0.96517	No
Bipolar I mania	2 (10.00)	2 (10.00)			
Delusional disorder	1 (5.00)	0 (0.00)			
Major depressive disorder	5 (25.00)	5 (25.00)			
Obsessive compulsive disorder	0 (0.00)	1 (5.00)			
Panic disorder	6 (30.00)	5 (25.00)			
Schizophrenia disorganized	1 (5.00)	1 (5.00)			
Schizophrenia paranoid	3 (15.00)	3 (15.00)			
Schizoaffective disorder	1 (5.00)	2 (10.00)			
Diagnosis (Axis II)					
Personality disorder (schizoid)	1 (5.00)	0 (0.00)	1.444444	0.485672	No
Personality disorder (obsessive)	0 (0.00)	0 (0.00)			
Personality disorder (paranoid)	2 (10.00)	1 (5.00)			
No diagnosis	17 (85.00)	19 (95.00)			

(*P*=0.6326 and 0.6773), and EES1 (*P*=0.7491 and 1) (Figs. 1–4).

There were no statistically significant differences between the 2 sexes as regard psychometric assessments at baseline or after group therapy. Along the time period of the study, no sex difference in regularity of attendance of group sessions for patients in group MGp and FGp (Figs. 5 and 6,) and patients' assessment of group cohesion process generally increased along the 12 months as denoted by GCQ-S (Fig. 7).

Follow-up psychometric readings after 1 year (Tables 4 and 5) revealed that patients attending group therapy (MGp and FGp) demonstrated variable levels of improvement compared with other groups of patients not attending group therapy (MCm and FCm), as well as compared with controls (MCl and FCl).

FOF2 (Fig. 8) demonstrated definite improvement in the MGp group compared with the MCm group (*P*=0.0283), and definite improvement in the FGp group compared with the FCm group (*P*=0.0480); however, improvement was beyond normality compared with control groups (MCl and FCl) (*P*<0.00001).

All TMMS2 (Fig. 9) scores of patients increased on treatment regardless of attending group therapy or not. Improvement in males reached normal levels compared with controls (*P*=0.1220 for the three male groups), but not in female patients (*P*=0.0021 for FGp vs. FCl). However, FGp patients showed more improvement than the FCm group (*P*=0.0044).

AAS2 (Fig. 10) demonstrated definite improvement in scores of all groups of patients after treatment with no significant difference between MGp and MCm groups (*P*=0.6756) or between FGp and FCm groups (*P*=0.1903); however, improvement was beyond normality in comparison with control groups (*P*<0.00001).

EES2 (Fig. 11) demonstrated definite improvement in the MGp group compared with the MCm group (*P*=0.01813) and in the FGp group compared with the FCm group (*P*=0.038434); improvement reached normality when compared with control groups (*P* is nonsignificant).

Comparison among all psychometric tests at baseline and after 1 year of follow-up revealed statistically significant differences only among patients attending group therapy regarding fears about failure (FOF1 and FOF2) in the MGp group (*P*=0.005482) and FGp (*P*=0.0253), emotional orientation as measured by TMMS1 and TMMS2 in the MGp group (*P*=0.018125) and the FGp group (*P*=0.0015), and emotional empathy (EES1 and EES2) in the MGp group (*P*=0.003289) and the FGp group (*P*=0.0012). However, comparison between anger expression at baseline and after 1 year (AAS1 and AAS2) in all groups revealed statistically significant differences among male patients attending group therapy (MGp) (*P*=0.045697) but not among female patients (FGp) attending group therapy (*P*=0.0785); moreover, anger expression showed a significant difference with improvement on regular treatment after 1 year in comparative group of patients MCm (*P*=0.0219) and FCm (*P*=0.0007) who were not attending psychotherapy.

Table 4 Psychometric assessment of all male groups

Data	Male group (n=20) [n (%)]	Males comparative (n=20) [n (%)]	Male control (n=20) [n (%)]	Statistics		
				χ^2	*P*	Significance
FOF1 (total)						
No (32)	0 (0.00)	0 (0.00)	0 (0.00)	44.117647	<0.00001	Yes
Mild (33–64)	0 (0.00)	0 (0.00)	15 (75.00)			
Moderate (65–96)	6 (30.00)	6 (30.00)	5 (25.00)			
Severe (97–128)	14 (70.00)	14 (70.00)	0 (0.00)			
Mean±SD	106.9±14.87	105.85±13.88	56.7±15.4			
FOF2 (total)						
No (32)	0 (0.00)	0 (0.00)	0 (0.00)	49.24183	<0.00001	Yes
Mild (33–64)	1 (5.00)	0 (0.00)	16 (80.00)			
Moderate (65–96)	15 (75.00)	8 (40.00)	4 (20.00)			
Severe (97–128)	4 (20.00)	12 (60.00)	0 (0.00)			
Mean±SD	83.5±12.31	100.75±14.33	53.9±12.02			
TMMS1						
High (91–150)	3 (15.00)	2 (10.00)	11 (55.00)	12.443182	0.0020	Yes
Low (30–90)	17 (85.00)	18 (90.00)	9 (45.00)			
Mean±SD	70.05±13.96	74.95±11.99	94.1±15.12			
TMMS2						
High (91–150)	10 (50.00)	5 (25.00)	11 (55.00)	4.208145	0.1220	No
Low (30–90)	10 (50.00)	15 (75.00)	9 (45.00)			
Mean±SD	94.15±14.43	80.1±14.25	94.65±12.34			
AAS1						
No (32)	0 (0.00)	0 (0.00)	16 (80.00)	44.571429	<0.00001	Yes
Mild (33–64)	12 (60.00)	12 (60.00)	4 (20.00)			
Moderate (65–96)	8 (40.00)	8 (40.00)	0 (0.00)			
Severe (97–128)	0 (0.00)	0 (0.00)	0 (0.00)			
Mean±SD	117.6±10.56	116.75±10.9	68.65±11.02			
AAS2						
No (32)	2 (10.00)	1 (5.00)	17 (85.00)	36.856757	<0.00001	Yes
Mild (33–64)	16 (80.00)	18 (90.00)	3 (15.00)			
Moderate (65–96)	2 (10.00)	1 (5.00)	0 (0.00)			
Severe (97–128)	0 (0.00)	0 (0.00)	0 (0.00)			
Mean±SD	98.65±13.81	95.15±11.6	69.2±11.56			
EES1						
High (91–150)	8 (40.00)	9 (45.00)	18 (90.00)	12.48	0.0020	Yes
Low (30–90)	12 (60.00)	11 (55.00)	2 (10.00)			
Mean±SD	86.75±18.23	87.7±17.04	106.75±9.39			
EES2						
High (91–150)	17 (85.00)	10 (50.00)	19 (95.00)	12.484472	0.001946	Yes
Low (30–90)	3 (15.00)	10 (50.00)	1 (5.00)			
Mean±SD	101.9±10.34	89.85±10.89	107.15±7.91			

AAS, Arabic Anger Scale; EES, Emotional Empathy Scale; FOF, Fear Of Failure; TMMS, Trait Meta Mood Scale.

Finally, a sex-based comparison of the scores of patients attending group therapy (Table 6) showed no sex-related statistically significant difference in psychometric assessments at baseline or after group therapy. Therefore, we preferred to include control groups (control groups MCl and FCl) as references to UAE society, particularly with using descriptive rather than clear-cut scales.

Discussion

Since the shift in mental health services from just an emphasis on treatment focusing on reducing symptoms to a more holistic approach considering both well-being and functioning (Gladis *et al.*, 1999), a wide range of clinical research is highly concerned about patients' quality of life (Connell *et al.*, 2012). Researchers are continuously working to achieve progress in understanding the role of psychotherapy in the treatment of mental disorders – a highly disabling illness – to achieve better quality of life (Van Weel, 1980; De Jonghe *et al.*, 2001; Burnand *et al.*, 2002; Jindal and Thase, 2003; De Maat *et al.*, 2008; IsHak *et al.*, 2011). Our study responded to colleagues' recommendation for further researches exploring how psychotherapeutic interventions tend to optimize the benefits for

Table 5 Psychometric assessment of all female groups

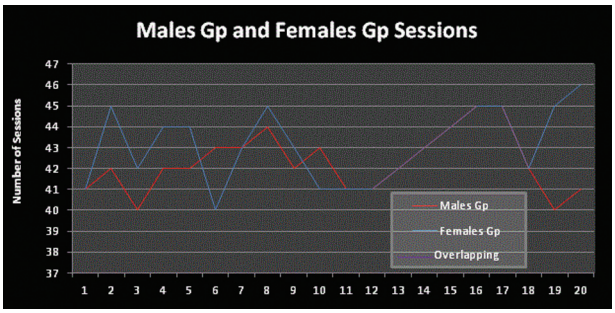
Data	Female group (n=20) [n (%)]	Female comparative (n=20) [n (%)]	Female control (n=20) [n (%)]	Statistics		
				χ^2	*P*	Significance
FOF1 (total)						
No (32)	0 (0.00)	0 (0.00)	0 (0.00)	45.840517	<0.00001	Yes
Mild (33–64)	0 (0.00)	0 (0.00)	15 (75.00)			
Moderate (65–96)	7 (35.00)	4 (20.00)	5 (25.00)			
Severe (97–128)	13 (65.00)	16 (80.00)	0 (0.00)			
Mean±SD	104.15±14.97	102.2±9.51	58.3±9.69			
FOF2 (total)						
No (32)	0 (0.00)	0 (0.00)	0 (0.00)	37.212418	<0.00001	Yes
Mild (33–64)	2 (10.00)	0 (0.00)	14 (70.00)			
Moderate (65–96)	13 (65.00)	8 (40.00)	6 (30.00)			
Severe (97–128)	5 (25.00)	12 (60.00)	0 (0.00)			
Mean±SD	84.95±11.74	100.35±9.66	58.75±9.26			
TMMS1						
High (91–150)	4 (20.00)	3 (15.00)	16 (80.00)	22.13866	<0.00001	Yes
Low (30–90)	16 (80.00)	17 (85.00)	4 (20.00)			
Mean±SD	77.35±10.88	77.6±11.67	102.45±13.38			
TMMS2						
High (91–150)	14 (70.00)	5 (25.00)	15 (75.00)	12.352941	0.0021	Yes
Low (30–90)	6 (30.00)	15 (75.00)	5 (25.00)			
Mean±SD	98.7±13.18	80.5±13.02	104.35±12.9			
AAS1						
No (32)	0 (0.00)	0 (0.00)	17 (85.00)	48.597222	<0.00001	Yes
Mild (33–64)	13 (65.00)	11 (55.00)	3 (15.00)			
Moderate (65–96)	7 (35.00)	9 (45.00)	0 (0.00)			
Severe (97–128)	0 (0.00)	0 (0.00)	0 (0.00)			
Mean±SD	115.5±8.86	115.55±10.84	66.05±11.31			
AAS2						
No (32)	2 (10.00)	5 (25.00)	18 (90.00)	32.450909	<0.00001	Yes
Mild (33–64)	16 (80.00)	15 (75.00)	2 (10.00)			
Moderate (65–96)	2 (10.00)	0 (0.00)	0 (0.00)			
Severe (97–128)	0 (0.00)	0 (0.00)	0 (0.00)			
Mean±SD	98.15±13.49	92.75±12.22	65.45±11.86			
EES1						
High (91–150)	7 (35.00)	7 (35.00)	20 (100.00)	22.941176	<0.00001	Yes
Low (30–90)	13 (65.00)	13 (65.00)	0 (0.00)			
Mean±SD	84.35±18.24	88.05±14.17	109.9±7.33			
EES2						
High (91–150)	17 (85.00)	11 (55.00)	20 (100.00)	13.125	0.001412	Yes
Low (30–90)	3 (15.00)	9 (45.00)	0 (0.00)			
Mean±SD	102±10.1	90.75±17.63	107.9±5.91			

AAS, Arabic Anger Scale; EES, Emotional Empathy Scale; FOF, Fear Of Failure; TMMS, Trait Meta Mood Scale.

patients. We specified certain parameters, which we believe are highly related to improving patients' quality of life. We tried to investigate how much these parameters were affected – if any – by conducting psychodynamic group psychotherapy sessions along with patients' treatment plans.

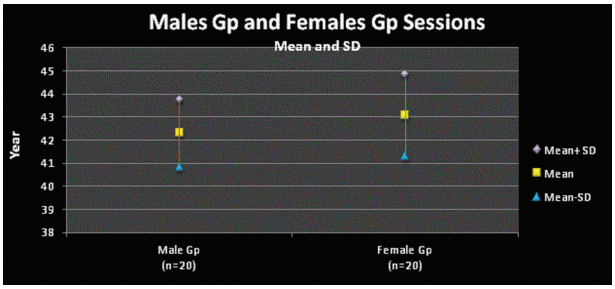
However, research in psychotherapy is difficult, especially trials using descriptive psychometric tests to assess personal and emotional experiences. Most of the Arabic tools used in the current study were either translated or built in the Egyptian community. Although Arab cultures have unique characteristics in common, they differ from one society to another (Haggag, 2001; Al-Sherbiny, 2005). Therefore, in our study, we preferred to include a volunteer group from the community (control groups MCl and FCl) as a reference to UAE society, particularly with using scales with descriptive rather than clear-cut scores for normality. All sharing individuals in these control groups (MCl and FCl) were hospital employees, which made occupation the only demographic data with statistically significant difference between the six groups that were sharing in the study ($P<0.0000001$);

Figure 1



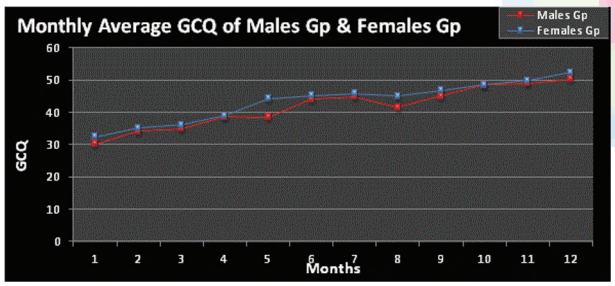
Fear Of Failure (FOF1) scores of all groups.

Figure 2



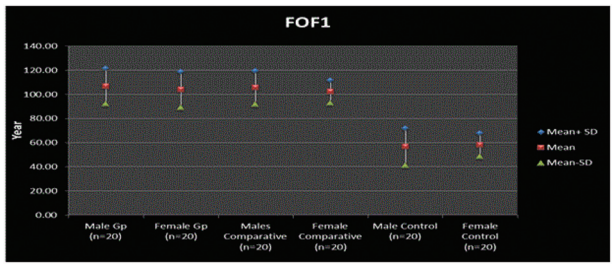
Arabic Anger Scale (AAS1) scores of all groups.

Figure 3



Trait Meta Mood Scale (TMMS1) scores of all groups.

Figure 4

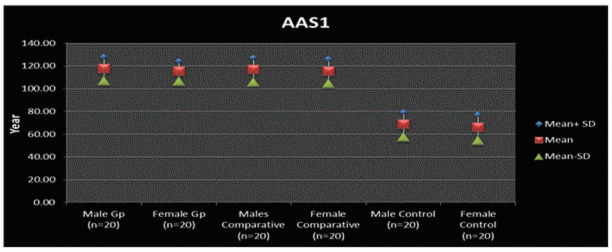


Emotional Empathy Scale (EES1) scores of all groups.

however, it did not vary significantly among the four sharing groups of patients (P=0.1174).

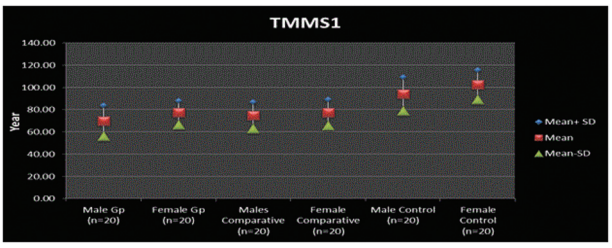
We agree with Yalom (1995) that the client's level of motivation to work is the most important variable in

Figure 5



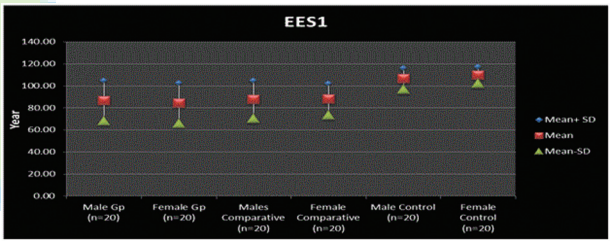
Male and female attendance in group sessions.

Figure 6



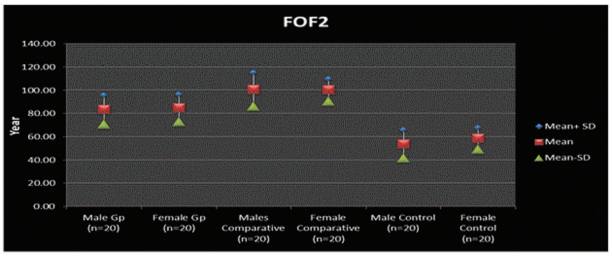
Male and female attendance in group sessions (mean and SD).

Figure 7



Monthly average GCQ of males and females.

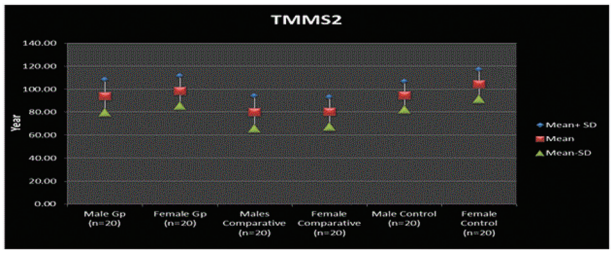
Figure 8



Fear Of Failure (FOF2) scores of all groups.

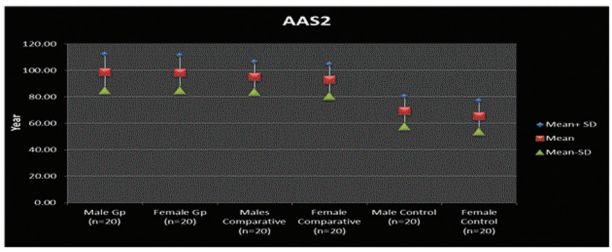
assuring attendance and cohesiveness of participants, and therefore both group members (MGp and FGp) who voluntarily chose to join group therapy showed similar attendance regardless of sex differences. Unless there are exceptional circumstances, nonattendance could be due to reluctance, resistance, or a passive aggressive reaction, especially if it follows a session of significant interaction or confrontation. Nonattendance does not

Figure 9



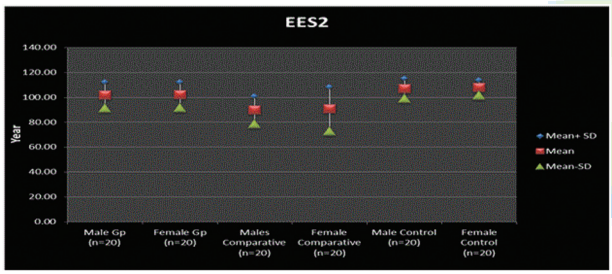
Trait Meta Mood Scale (TMMS2) scores of all groups.

Figure 10



Arabic Anger Scale (AAS2) scores of all groups.

Figure 11



Emotional Empathy Scale (EES2) scores of all groups.

allow checking with the member and this adds to leader difficulties in expectation, challenging therapists to wait for further case follow-up (Hill and Harris, 2011); therefore, we did our best to assure attendance of each patient in the male group (MGp) and the female group (FGp) for at least 40 sessions in a closed group for 1 year by including such an item in the contract.

To share in groups, participants are encouraged to be open, and this is a risk regarding privacy with no guarantee of respecting confidentiality by other group members (Corey *et al.*, 2007). Moreover, group participation has a risk of group pressure to share. This may affect patient satisfaction with ethical dilemma as well (Ellis *et al.*, 1989). Individuals are at risk of being the scapegoat or face harmful confrontation by group members if they attend groups with disruptive behaviors (e.g. hallucinatory attitude or overwhelming anxiety). This would negatively affect their self-esteem and interpersonal relations (Hill and Harris, 2011).To minimize all these risks, the contract specified therapists' roles and responsibilities as well as members' commitments to groups. This helped in limiting negative experiences and damage to patients with clarification of expectations of participants. However, as mentioned by Corey *et al.* (2007), using a contract might not be sufficient in itself, and therefore we considered it is more important to have a well-trained leader in the group along with experienced co-leaders to prevent unnecessary harm to participants.

We preferred unisex groups in our study not only as a culture-oriented center respecting UAE population traditions but also believing in the positive impact of unisex groups for females as encouraged by Greenfield *et al.* (2013). They mentioned that women in single-sex groups felt safe, had their needs met, and felt intimacy, empathy, and honesty. Moreover, group cohesion and support would allow women to focus on sex-relevant topics, supporting their improvement with higher satisfaction and better treatment outcomes.

A person's cognitive style – although still debatable in its definition – is mostly mentioned to be his or her preferred way of looking at or interacting with the world, tending to be the same throughout life, under the influence of other factors such as personality, heredity, and/or brain injury (Newman and Beck, 2009). In the present study, we selected scales that cover main cognitive styles mentioned to be negatively affected in mentally ill patients, assessing low self-esteem (Scott and Pope, 2003; Jones *et al.*, 2005; and Knowles *et al.*, 2007) as well as the major problem of easy provocation and anger control (Gouliaev *et al.*, 1996). Empathy – which is mentioned to be related to cognitive styles as well (DeVore *et al.*, 1989) – together with a person's orient ation to emotion were also assessed in our present study.

Definite psychometric assessment differences were detected in our patients compared with normal controls early in the study, with higher levels of fears about failure (FOF1) denoting lack of self-confidence, inferiority feelings, and negative expectations about/of others, as well as negative perception of competition, in all patients groups compared with control groups ($P<0.00001$) (Tables 4 and 5). However, differences between the four groups of patients [(MGp vs. MCm) and (FGp vs. FCm)] were nonsignificant ($P=1$ and 0.28809, respectively) as shown in Fig. 1. The majority [14 (70%)] of male patients in both MGp and MCm groups had severe degree of fears about failure compared with the majority [15 (75%)] in the control group (MCl) with only mild fears about failure (Table 4). Similar results were found in

Table 6 Sex differences in psychometric test scores in patients attending group therapy

Data	Male group (n=20) [n (%)]	Female group (n=20) [n (%)]	Statistics		
			χ^2	*P*	Significance
FOF1 (total)					
No (32)	0 (0.00)	0 (0.00)	0.11396	0.73568	No
Mild (33–64)	0 (0.00)	0 (0.00)			
Moderate (65–96)	6 (30.00)	7 (35.00)			
Severe (97–128)	14 (70.00)	13 (65.00)			
Mean±SD	106.9±14.87	104.15±14.97			
FOF2 (total)					
No (32)	0 (0.00)	0 (0.00)	0.587302	0.7455	No
Mild (33–64)	1 (5.00)	2 (10.00)			
Moderate (65–96)	15 (75.00)	13 (65.00)			
Severe (97–128)	4 (20.00)	5 (25.00)			
Mean±SD	83.5±12.31	84.95±11.74			
TMMS1					
High (91–150)	3 (15.00)	4 (20.00)	0.17316	0.6773	No
Low (30–90)	17 (85.00)	16 (80.00)			
Mean±SD	70.05±13.96	77.35±10.88			
TMMS2					
High (91–150)	10 (50.00)	14 (70.00)	1.666667	0.1967	No
Low (30–90)	10 (50.00)	6 (30.00)			
Mean±SD	94.15±14.43	98.7±13.18			
AAS1					
No (32)	0 (0.00)	0 (0.00)	0.106667	0.7440	No
Mild (33–64)	12 (60.00)	13 (65.00)			
Moderate (65–96)	8 (40.00)	7 (35.00)			
Severe (97–128)	0 (0.00)	0 (0.00)			
Mean±SD	117.6±10.56	115.5±8.86			
AAS2					
No (32)	2 (10.00)	2 (10.00)	0	1.0000	No
Mild (33–64)	16 (80.00)	16 (80.00)			
Moderate (65–96)	2 (10.00)	2 (10.00)			
Severe (97–128)	0 (0.00)	0 (0.00)			
Mean±SD	98.65±13.81	98.15±13.49			
EES1					
High (91–150)	8 (40.00)	7 (35.00)	0.106667	0.7440	No
Low (30–90)	12 (60.00)	13 (65.00)			
Mean±SD	86.75±18.23	84.35±18.24			
EES2					
High (91–150)	17 (85.00)	17 (85.00)	0	1.0000	No
Low (30–90)	3 (15.00)	3 (15.00)			
Mean±SD	101.9±10.34	102±10.1			

AAS, Arabic Anger Scale; EES, Emotional Empathy Scale; FOF, Fear Of Failure; TMMS, Trait Meta Mood Scale.

female groups (Table 5), as the majority [13 (65%)] of FGp group reported severe degree of fears about failure versus 16 patients (80%) in the FCm group, compared with only mild degree in the majority [15 (75%)] of female control group (FCl).

A comparison between FOF1 assessed at baseline and FOF2 after 1 year of follow-up revealed statistically significant differences only among patients attending group therapy regardless of sex (Table 6). Average mean scores of FOF reduced in the MGp group from FOF1 (106.9±14.87) to FOF2 (83.5±12.31) compared with little change in the MCm group FOF1 (105.85±13.88) to FOF2 (100.75±14.33) as shown in Table 4. Female groups (Table 5) showed similar discrepancy between FGp and FCm after group therapy, reducing in the FGp group from FOF1 (104.15±14.97) to FOF2 (84.95±11.74) compared with very little change in the FCm group FOF1 (102.2±9.51) to FOF2 (100.35±9.66). However, such improved scores in MGp and FGp groups failed to reach normality and were still beyond the control group mean scores (53.9±12.02 and 58.75±9.26) for MCl and FCl, respectively. This could be

explained partly by the fact that all control group volunteers were already working staff of the hospital, and this might have had a positive impact on their FOF scores. Job functioning may be maintaining the control population's self-esteem high enough with more self-confidence and less feelings or fears of failure compared with the patient population whose mental illness might be affecting their functioning negatively enough to impair their achievement abilities at work or studies (Connell *et al.*, 2012).

Our results are in agreement with the results of Fakhry *et al.* (2013)regarding the privilege of attending psychotherapy with significantly (P=0.00000) lower mean scores of FOF (83.42±12.08) in euthymic bipolar patients, compared with those who did not receive psychotherapy in their treatment plans (105.37±10.48). Results of the present study show a similar significant lowering of the same scores when compared before and after group therapy; however, patients in our sample had heterogeneous psychiatric diagnoses compared with only bipolar patients in the other study. Regardless of specificity of diagnosis in the other study, as their patients were in euthymic state after treatment, it was interesting to find the same difference between patients scores – even in euthymic state – and control sample scores (bipolar manic (BPM) 93.46±10.67, bipolar depressive (BPD) 96.73±19.51 compared with 46.67±9.19 in controls). This finding draws attention to the negative impact of mental illness on parameters assessed in FOF as self-confidence and self-esteem among psychiatric patients in general (Connell *et al.*, 2012). A message can be carried about the clinical implications, mandating good care of these topics in treatment programs and stressing on the importance of dealing with such fears in group treatment facilities to help patients achieve better quality of life after recovery.

Although the majority of patients in the control groups [16 (80%)] MCl and [17 (85%)] FCl expressed no anger at baseline assessment using Arabic anger scale (AAS1) (Tables 4 and 5), all patients in the four patient groups showed variable degrees of anger ranging from mild anger in 12 (60%) in both MGp and MCm groups and 13 (65%) and 11 (55%) in FGp and FCm groups, respectively, to moderate degree in 40% of male patients in both MGp and MCm groups and 35 and 45% of patients in FGp and FCm groups, respectively. A comparison between anger expression at base line and after 1 year (AAS1 and AAS2) in all groups revealed statistically significant differences among male patients attending group therapy in MGp [AAS1 (117.6± 10.56) and AAS2 (98.65±13.81), P=0.045697] but not in female patients attending group therapy in FGp [AAS1 (115.5±8.86) and AAS2 (98.15±13.49), P=0.0785]. In addition, patients in comparative groups showed significant difference with improvement of anger control on regular treatment after 1 year in MCm [AAS1 (116.75±10.9) and AAS2 (95.15±11.6), P=0.0219] and FCm [AAS1 (115.55±10.84) and AAS2 (92.75±12.22), P=0.0007] groups. This assures importance of pharmacological treatment to control psychiatric patients' anger to avoid violent acts and easily provoked outbursts. Again, our results simulated (Fakhry *et al.*, 2013) significant differences between normal controls and euthymic bipolar patients when comparing mean scores of AAS (BPM 107.4±15.55, BPD 71.66±15.89 compared with 66.03±11.75 in control, P=0.0001). However, although our sample of patients showed privilege effect for psychotherapy attendance only among male patients but not female patients, the sample of the study of Fakhry and colleagues showed a significant lower mean score of AAS in patients who joined psychotherapy in their treatment plans (76.03±23.90 compared with 101.47±16.58). The difference may be due to inclusion of both sexes in their sample without differentiation; therefore, sex effect could not be tested in their study. For both studies, patients after treatment, although having significant improvement in anger expression, could not reach normal levels, and this may be related to the negative impact of developing mental illness over anger control and easy provocation. Female patients attending group therapy failed to show significant improvement in anger expression compared with those not attending group therapy and could not reach normal levels either, and this may be directly related to the group dynamics. Patients in group therapy are encouraged to express their feelings including anger in a permissive attitude within the therapeutic plan. With this, self-awareness to hostile attitudes increases and further steps continue toward achieving anger control and self-expression in more positive attitudes.

Emotional orientation problems were also definite in patients groups early in illness showing lower levels of orientation to emotions. This was evident as measured by TMMS1 in 17 (85%) of MGp and 18 (90%) of MCm compared with only nine (45%) in the control group MCl (P=0.0020) (Table 4). Similarly, the majority of female patients [16 (80%) of FGp and 15 (75%) of FCm] reported low degree of orientation to emotions compared with only four (20%) in the female control group FCl and P<0.00001 for comparing TMMS1 mean scores of the three female groups (Table 5). However, differences between the four groups of patients [(MGp vs. MCm) and (FGp vs. FCm)] were

nonsignificant in TMMS1 (P=0.6326 and 0.6773, respectively) (Fig. 3).

All TMMS2 (Fig. 9) scores in the four groups of patients increased on treatment regardless of attending group therapy or not. Mean scores of TMMS2 reached 94.15±14.43, 80.1±14.25, 98.7±13.18, and 80.5±13.02 for MGp, MCm, FGp, and FCm groups, respectively, compared with 70.05±13.96, 74.95±11.99, 77.35±10.88, and 77.6±11.67 in TMMS1 before treatment. Improvement in TMMS2 of male patients in MGp reached normal levels compared with 94.65±12.34 for MCl, but the mean score of female patients in FGp was still significantly lower than that of the normal control female group FCl (104.35±12.9, P=0.0021 for FGp vs. FCl). However, FGp patients showed more improvement than the FCm group (P=0.0044). Our results showing positive impact of group therapy on emotional orientation are totally in agreement with the findings of Gohar and colleagues in their study conducted on 42 patients with schizophrenia in Egypt. Twenty-two patients were randomized to 16 sessions of group-based social cognitive skills training and 20 were randomized to a format-matched and time-matched skill management training control. Preintervention and postintervention assessments that included four branches of MSCEIT emotional intelligence test (Mayer *et al.*, 2002) showed significant treatment effects on total emotional intelligence scores as well as the subareas of identifying emotions and managing emotions, compared with those in the control condition (Gohar *et al.*, 2013). In addition, those findings are consistent with previous findings of Gratz and Gunderson in their study, which indicated positive effects of group intervention on emotional dysregulation in women with borderline personality disorder. Participants in the group treatment showed evidences of significant changes over time on all measures assessing emotional regulation, self-harm, avoidance, stress, depression, and anxiety. Contrary to our results, improvement of their female patients reached normal levels of functioning on most measures. They themselves considered their small size sample (N=12) as limitation to generalization and recommended further studies with larger randomized controlled samples (Gratz and Gunderson, 2006).

Compared with the high degree of empathy reported in all (100%) normal control females in the FCl group (mean±SD=109.9±7.33) (Table 5) and 90% of males in the control group MCl (mean±SD=106.75±9.39) (Table 4), patient groups reported low degrees of empathy in 60% of MGp, in 55% of MCm (Table 4), and in 65% of both FGp and FCm (Table 5) using EES1; but differences between the four groups of patients [(MGp vs. MCm) and (FGp vs. FCm)] were nonsignificant (P=0.7491 and 1) (Fig. 4). All EES2 (Fig. 10) scores of the four groups of patients increased on treatment regardless of attending group therapy or not. Mean scores of EES2 reached 101.9±10.34, 89.85±10.89, 102±10.1, and 90.75±17.63 for MGp, MCm, FGp, and FCm, respectively, compared with 86.75±18.23, 87.7±17.04, 84.35±18.24, and 88.05±14.17 in EES1 before treatment. However, comparing scores of emotional empathy (EES1 and EES2) showed significant difference only in MGp (P=0.003289) and FGp (P=0.0012).

Empathy is always attributed to violence and aggressive behavior in patients with schizophrenia. Empathy among our heterogeneous group of patients showed significant improvement in the sample as a whole as we did not specify measurement to certain diagnosis. We agree with Johnson *et al.* (2005) that group members differentiated relationships primarily according to the relationship quality rather than the status or role of others being leader, member, or the whole group. Impairments in eye contact are characteristic of those with callous, unemotional traits (Dadds *et al.*, 2012). An inclination to attend to other people's emotions is a necessary condition for human empathy. We find our rule of I – thou as a key to human interactions and relations in the working group, and hence this is the way we believe patients achieve improvement in empathic feelings toward others. Unfortunately, empathy in group therapy literature is always concerned with therapist–patient relationship (Van Weel, 1980; Patterson, 2000), although empathy means caring that is expressed in a group by genuine and active involvement with other group members, either therapists or patients. With sharing of painful experiences and disclosure of struggles, joy, excitement, and fears, group members make it possible for others to care and express emotions toward them. Empathy bridges the communication gaps between different people promoting more intimacy and cohesiveness (Corey, 2012).

As Rakhawy (2001) mentioned 'no psychotherapy without assessment', our study tried not only to compare parameters of psychometric scales but also to evaluate the whole process, considering the group cohesion process. GCQ is one of the most commonly used measures in group psychotherapy research (Burlingame *et al.*, 2003). Results showed that cohesion increased along the 12 months as denoted

by patients' assessment using GCQ-S (Fig. 7). This increase along time replicates the findings of Kamal *et al.* (2009) in their study of group therapy sessions for 24 months. They reported fluctuation in GCQ-S with final increase in engagement and decrease in conflicts across sessions. Cohesion is a strong determinant for positive group outcome as it fosters therapeutic factors to operate (Yalom, 2005). It is a valuable concept that can be a unifying force for group members. However, it does not occur automatically, but it is the result of commitment of group members and leaders to take steps toward a 'group-as-a-whole' feeling. Therapeutic alliance after perceiving acceptance helps in development of belonging to groups and being involved in multiple cohesive relationships (member to leader and member to member and member to group). Trust feelings, honest sharing, and openness to deeper level, taking risk to be seen, and willing to reveal painful experiences need cohesion to occur and in turn simultaneously help more cohesiveness of the group (Burlingame *et al.*, 2002). Cohesion characters vary from one group to another but can be identified by here and now focus, clear goals and concerns, willing to work and participate, ending in an orchestra-like feeling among members, and a leader with willingness to take steps to change matters. Ultimately, cohesion leads to a more productive group work with trust and acceptance, empathy and caring, intimacy, hope, free dom to experiment, catharsis expression, cognitive reconstruction, commitment to change, and feed back with both confrontation and self-disclosure abilities. (Corey, 2012).

Finally, we find ourselves in agreement with all preceding clinical studies recommending combining psychotherapy and pharmacotherapy to improve patients' quality of life (De Jonghe *et al.*, 2001; Jindal and Thase, 2003; Furukawa *et al.*, 2006; De Maat *et al.*, 2008; IsHak *et al.*, 2011; Fakhry *et al.*, 2013; Gohar *et al.*, 2013).We believe that psychodynamic-oriented psychotherapy may be reaso nable to improve the long-term outcomes of mental disorder patients (Rakhawy, 2001; Burnand *et al.*, 2002), and our results support the recommendations of Martinez-Aran *et al.* (2004) of psychoeducational psychotherapy to have a more positive impact on the successful management of mental illnesses.

Conclusion

(1) Group therapy has been successfully accepted among UAE psychiatric patients, improving their fears about failure and empathy and to variable degree orientation to emotions but not anger expression.
(2) Group cohesion process did not differ significantly in unisex group therapy when structure was maintained to assure similar attendance among both group members. Differences were related to environmental events rather than being sex related.

Clinical implications

(1) Practice of group therapy has been successful in UAE closed community culture against the presumption that patients could reject the idea of self-disclosure in the presence of strangers, when culture traditions are respected by separating sexes in the group.
(2) The improvement of fears about failure within patients attending group therapy is still beyond normality compared with control groups, drawing attention to the importance of dealing with such fears in group treatment facilities.
(3) Empathy improvement and cognitive orientation of emotions within patients attending group therapy could reach normality especially in male patients, whereas female patients' improvement exceeded the improvement in patients who did not attend the group but failed to reach normality levels in emotional orientation, which might reflect the long-term sequels of illness on female emotions.
(4) Patients attending group therapy failed to show significant improvement in anger expression compared with those not attending group therapy and could not reach normal levels; this may be related to the group experience permitting more ventilation and lowering repression of aggressive feelings within the therapeutic milieu.

Limitations

Some factors in this study might limit the generalization of the results, such as the following:

(1) Choice of patients was not randomized, and therefore patients who chose to join the group may have personality characters and dynamic reactions different from other patients who chose not to join group therapy. Although the impact of personality characters and cognitive styles on their benefit of group experience could not be excluded, we find this very realistic and natural, affecting prognosis of patients.

(2) Selected patients in our study when recruited were not drug free, with regard to ethical reasons as well as for being a naturalistic study, as psychiatrists rarely practice psychotherapy without other means of therapeutic agents (De Jonghe *et al.*, 2001; Rakhawy, 2001; Jindal and Thase, 2003; and IsHak *et al.*, 2011).
(3) Regarding occupation, all volunteers of the control groups were working hospital staff, which may have had a positive impact on their 'Fears Of Failure' scores compared with patient groups.
(4) Most of our results are based on subjective experiences of clients, but we find this to be the true challenge in group experience assessment.

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