REPORT ON VARIOUS EXPERIENCES IN GROUP PSYCHOTHERAPY*

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Introduction

DURING the last two years a very large amount of literature on group therapy has been published with a great variety of techniques, and has been applied to different types of patient material. At the 1948 Annual Meeting of the American Psychiatric Association in Washington, six papers on group psychotherapy were presented in a single session, besides a number of others given in connection with other psychiatric topics.

My own interest in group therapy started 24 years ago when I was a resident at a University Institute for Forensic Medicine. The head of my department intended to write a book on unorthodox healing methods in medicine and urged me to join a Mazdasnan group working with an East Indian method of treating somatic symptoms by group exercises of breathing, by exhortations and diets. At that time I first became aware that Mesmerism had used the same method in working with groups and that Christian Science and its relation, Alcoholics Anonymous, are spiritual descendants of Mesmer as well as were the more modern French schools of psychiatry which used hypnotism: The Nancy School and Charcot whose pupil was Sigmund Freud.

Through the Salvation Army and Alcoholics Anonymous I have become interested in group methods, in child education as well as in the rehabilitation of alcoholics, but only since the second World War have I found occasion to observe and practice group psychotherapy on a more rational and scientific basis.

My own experiences during the last 5 years consist of:

1) A large number of therapeutic groups in various army installations, most of them in hospitals and treatment centers in the European theatre of operations; some of them close to the front line, others far back in holding centers, varying greatly in size, in patient material and duration of treatment.

2) For one year I have been supervising a number of groups in a large federal institution conducted by young psychiatrists, treating selected psychotic patients in various stages of deterioration or recovery. Some of those groups were large and devoted to orientation only, others were small and intended for intensive psychotherapy.

3) Over a period of 10 months, I have conducted together with Dr. Anne Herzman, in private practice, a group composed of war veterans of both sexes who were at the same time under intensive individual psychotherapy.

4) In New York, overseas and during research projects at the University of Michigan I have seen a number of psycho-drama projects in action. I have participated, but never conducted them.

5) During the last 18 months, I have worked with a number of small groups of children partly conducted by myself partly conducted under my supervision.

A number of highly interesting and stimulating papers have been published on dynamics and theory of group therapy, but this paper does not intend to deal with questions of theory. I shall concentrate on eight practical points that have to be considered and observed carefully if one intends to do group psychotherapy. These eight points are:

1. Selection of Patients
2. Leadership—The Group Therapist
3. Optimal and Maximal Size of Groups
4. Analytic, Didactic or Inspirational Techniques
5. Frequency and Duration of Sessions, Duration of Treatment
6. Continuous Groups or Fixed Groups
7. Combinations of Group and Individual Psychotherapy
8. Training, Supervision, and Evaluation of Group Sessions.

I. Selection of Patients

Success or failure in group therapy depends largely on the care and judgment one has to use while selecting the patients. I feel that the question of homogenous and heterogenous groups so widely discussed in literature is not very meaningful. Does it mean that the patients should have the same nosological diagnosis or the same symptoms in order to make up a homogenous group? Should all patients complain about stomach aches or should all patients be enuretics? These groups are as little homogenous in the dynamic sense as would be a group made up entirely of redheads. I feel that it is dangerous to sample people according to superficial symptomatology since by such a procedure we overemphasize the importance of a symptom rather than bring to the foreground the importance of unconscious dynamics of which the symptom is only a manifestation. Such a procedure in my opinion defeats to a large extent the very purpose of psychotherapy.

It is obvious that while working with psychotics, for instance, it would be impossible to conduct a group composed entirely of completely withdrawn schizophrenics. On the other hand schizophrenics and schizoid personalities do very well in mixed groups and feel much more comfortable and are often more cooperative in a group than in individual sessions.

This means that well-known and well-diagnosed patients should be selected according to their capacity of dealing with each other, working or exchanging opinions with each other, without hurting each other too much. If one makes this principle the leading agent, one will have less difficulties than if one applies any rigid scheme. Of course, the difference in age, in education and in basic intelligence should never vary too much in a given group. Mentally deficient as well as severely paranoid persons are never doing well in groups permitting spontaneous action. I shall indicate later how they might be able to profit in purely didactic groups.

I think that the representation of both sexes in a group is advantageous, as has been shown by the adolescent groups of Dr. Nathan Ackerman. I know that others do not share this opinion. As a rule relatives are difficult participants in the same group but Moreno as well as Miller and Baruch have conducted successfully groups with married couples. I will not close this short discussion, which of course leaves many things unsaid, without giving you

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one short case history from my own experience.

A very passive, latent homosexual, with a very severe lifelong stammer, had refused to participate in a group of stammerers which met at his college. When I asked him, with some hesitation, whether he would like to participate in a mixed group of patients which contained only one other mild stammerer, he consented right away. Using his good intelligence and education, he participated very actively in an interview group, was very happy and social. Drawing from his group experience, he expanded actively in his social life, which had been extremely restricted, outside the group. The group, which consisted of a majority of very irritable and at least two very aggressive members, showed extreme tolerance and helpfulness toward the severe speech difficulties of this patient.

II. Leadership—The Group Therapist

Here again the literature presents an enormous variety of requirements for good group leadership. It goes all the way from a very authoritarian attitude of the leader, as presented in the work of A. A. Low and even of G. W. Klapman, to the development of "Leaderless Groups" as described in the Northfield Experiment of an English group under the leadership of W. R. Bion. Active and passive, directive and non-directive leadership is disputed.

On this point I agree largely with Slavson that the leader should be very lenient and accept any behavior, and that at least in the beginning his presence should serve more as a catalyzer than anything else. I hate to have such a leader called passive; he should make the members feel that he is a very warm person with great empathy, and that he does not use the group as a looking glass experience which always would make him an outsider. He has to be part of the group otherwise there will be no leadership. Even in the report about the English leaderless group, I find the statement that nobody can give up leadership in a group if he never had it. The use of the word "group therapist" is therefore more appropriate than the word "leader," which is so often used and abused.

I find no better description of the ideal leader in group therapy than the remark of the French writer Flaubert who said that the relationship of the author to his book is what God is to the world: "He is always present but never visible." And this means good group leadership also.

It is obvious that leadership has to be developed, it is not given. Leadership has to develop on the level of the patient as Joseph Abrahams has shown in his work with criminal psychotic patients in Saint Elizabeth's Hospital in Washington. I was once told in a discussion that it is the task of the therapist to lift the patient up to the level of society which the therapist represents. But you never can lift anybody who has fallen down in a physical sense by standing stiffly in an upright position. To lift a person who has fallen, you have to go down on your knees. If you do not go down on your knees to the level of your patient first and make him feel that you join him where he is, you will never be able to help him, either physically or spiritually.

From this point of view I consider group psychotherapy not only a method of treating patients, but I think it has enormous value in educating our own staff members to accept every patient as an equal, in giving up the condescending attitude toward the hostile, the dumb and the criminal, that many of us still are inclined to take. While we can punish, we cannot help psychologically by such an attitude. Group psychotherapy

cannot be conducted by any person who is not willing to accept completely everyone of his patients. I have always been impressed by Slavson's case history of the "bad boy" who when asked what he meant by saying that he was "not loved" answered: "When people let me do what I want to do then I know that they love me." The same boy defined an institution for boys: "A place where people preach to you that what you have done is wrong and will always tell you to do right."

A group should represent a healthy community atmosphere and this is why I always like to have a co-leader of the other sex together with the therapist, especially with younger or immature group members since the prototype of the healthy group is still the representation of a family.

III. Analytic, Didactic or Inspirational Techniques

At this point, I have to be careful not to break my promise of not getting involved in theory and deeper group dynamics. I am convinced that the different techniques and basic approaches in group therapy can find their place in an overall setting only by agreeing that no one method is good and applicable for every given group of patients. I have already said that paranoid persons are dangerous as members of therapeutic groups, in the ordinary sense, and that mentally deficient persons do not profit from analytically oriented interview groups. Nevertheless, I have seen hostility in paranoid patients reduced greatly by a group procedure which, while being superficial, permitted orientation and free speech. I have also seen results from the application of purely didactic methods and habit training in mentally deficient persons or in deteriorated schizophrenics, epileptics or alcoholics. No "cure" of the basic condition is attempted in these groups, but the diminution of aggression in one group and of fear in the other improves behavior so that these patients are more manageable. I do believe that the authoritarian approach of Dr. Low with respect to his chronically sick, deteriorated patient material has some success in a social sense: namely that of restricting the patients to live in a given environment. Of course with this kind of treatment it is not the patient who becomes happier, but only society as represented by a restricting environment.

It has to be emphasized that mild situational neurosis, as combat fatigue, occurring in basically healthy persons who break down under an enormous impact of acute traumatization, very often benefits from a very superficial type of group therapy conducted in large groups on a permissive basis.

But the majority of psycho-neurotics who have been damaged in early childhood and who have a tendency to relapse again and again under stress, need treatment in small groups under analytically oriented leadership and need a therapy that deals with deeper unconscious conflicts. This method has been described so aptly by Mr. Slavson and others that I do not need to go into it at this point.

It is undeniable that certain patients who have a tendency to exhibit their conflicts and who are able to release tension through acting out, benefit through certain psycho-dramatic methods, but I think that this group of patients is fairly limited and that this method can do harm when applied to the wrong type of patient.

IV. Optimal and Maximal Size of Groups

It follows from the last chapter that

intensive analytically oriented therapy can be applied only to small groups in order to permit the therapist to observe closely not only the relation of each patient to himself but also the relations of the patients to each other. He has to guide the members so that they will be able to form a well-functioning, integrated group. This means in my opinion a group not smaller than 5 and not larger than 8 people. I agree with Alexander Wolf and others that too small a group increases friction and does not permit any easy interchange that is emotionally loaded. I have shown previously that orientation groups and didactic groups which use the lecture type or the inspirational procedure as employed by Alcoholics Anonymous, or by Pratt (who was the first to use scientific group therapy on a large scale in America) are able to deal with much larger groups of patients but the effect remains largely symptomatic. Even in those larger groups I do not think that scientific observation, in the most liberal sense, is possible if the group exceeds 15 or 20 persons. Anything beyond this I am unable to call therapy. Political mass meetings, religious prayer meetings, school classes, etc., are very admirable and necessary undertakings, but I feel very strongly that we should prevent ourselves and others from calling them therapy.

V. Frequency and Duration of Sessions, Duration of Treatment

Group psychotherapy as any other therapy deals with sick persons, meaning patients. Treatment has to be planned and medicine applied has to be dosed carefully under continuous observation. Even good medicine is harmful when applied carelessly.

Psychotherapy usually has to be planned over a long period of time for individuals as well as for groups. Interview group sessions have to be held at regular hours, the minimum is 45 minutes, the optimum is 90 minutes, the maximum is 2 hours. (I have insufficient experience in activity groups to talk about the time element authoritatively.) Cancellation of sessions is as dangerous in group psychotherapy as it is in individual psychotherapy because it means rejection and frustration to the patient. Very sick patients need daily treatment, at least 5 times a week. People who are less sick need less treatment but I do not think that any group as such can be maintained if it does not meet at least once a week.

Overtreatment is always harmful. A patient in psychotherapy usually shows definite signs when he has obtained the optimum of treatment. Those signs should be observed, carefully evaluated and the patient should not be forced to take treatment for a longer period of time than necessary.

VI. Continuous Groups or Fixed Groups

I think that with a large turnover, a group cannot be maintained. Even in a didactic group or in an orientation group the procedure is based on a certain amount of continuity. This does not mean that one has to be rigid. It is unavoidable that certain members leave the group if the group is planned over a longer period of time. But the replacement of members in a small group, with intensive psychoanalytic goals, is a disturbing factor for the group as such as well as for the members and while it may have occasionally good effects, the negative ones usually predominate. Klapman and Abrahams have conducted groups with psychotic patients, meeting in the midst of a ward, where the patients were free to join or to drop out. These were special situations dealing with patients who had little contact with reality. I feel that these observations were extremely interesting, but that such a procedure cannot be used in groups of children or adolescents.

VII. Combination of Group and Individual Psychotherapy

I have no doubts that in certain cases group psychotherapy is preferable to individual psychotherapy. In a large number of other cases individual psychotherapy alone is the only method to be used. Group psychotherapy has often been used in order to economize. It has been considered less expensive than individual therapy, less time consuming and easier to apply by an insufficiently trained staff. I am fully convinced that this is not so and that good group therapy needs more training, more time and therefore cannot be cheap. From my own experience a combination of individual and group psychotherapy is, in the majority of cases, preferable because of the differences in approach. Group psychotherapy permits much more the functioning of that part of the personality of the patient that is not diseased while individual psychotherapy concentrates its efforts on the diseased parts. The combination of both methods permits at present in many cases optimal therapeutic effect.

VIII. Training, Supervision, and Evaluation of Group Sessions

From the foregoing it is clear that whoever undertakes group psychotherapy today has a great responsibility not only toward his patients but also toward science. We are in a field that has expanded with enormous speed in order to meet urgent needs and in such a situation overenthusiasm and lack of discipline in thinking tempts us easily to go farther than we should. For this reason it is of great importance, now, that the war is finished, to apply to a civilian setting the most rigid methods possible, to observe objectively what is going on in a group and to evaluate it continuously. This is very often easier said than done. The procedure of recording, the presence of a person who takes minutes and who is therefore unable to participate, can easily be disturbing factors in the group procedure. Some projective techniques have been used before, during and after group psychotherapy sessions, in order to gain more objective material for the evaluation of the therapeutic process, but we need much more and better research work.

This is intimately connected with the question of training group psychotherapists. Mr. Slavson has published material on this topic and I have had occasion to sit on a steering committee trying to work out better and more scientific training facilities. This is not the place to enlarge on this topic, but I cannot close this paper without emphasizing the tremendous need for training in group therapy.

Summary

I have tried to show you with the help of eight selected points some of my experiences with group psychotherapy which began during and after the war, without proper preparation. What I have seen and observed, what I have read and learned from others, has greatly encouraged me to believe that group psychotherapy is an outstanding weapon in the treatment of mentally disturbed persons and of social ills that in their turn cause greater disturbances in groups and individuals.

We know that we have been successful in certain fields of group psychotherapy

but this is not enough. We have to know much more, *why* we are successful and *what* goes on in the individual who is a group member as well as what goes on in the group as a body with its own rights. Modern psychology has derived great insight into the psychology of the normal individual by exploring the dynamic mechanism of the neurotic. It stands to reason that the results of scientifically applied and evaluated group psychotherapy might enable us some day to understand better the great mystery of our times, namely the psychology of the masses.

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TECHNIQUES IN GROUP THERAPY*

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BOTH Mr. Slavson's and Dr. Hulse's presentations have, I think, shown quite impressively that the introduction of the group into psychotherapy has become widely accepted. Among those who have had intimate contact with this form of therapy as therapists and supervisors, there is no doubt as to its therapeutic value. While there are still many experiments going on, we are beyond the experimental stage, at least to some extent, in the area of work with children.

Mr. Slavson's presentation has shown that at the Jewish Board of Guardians four definite group-therapy methods are at this time being employed, all of which are applied with an appreciable degree of certainty and skill. The degree of certainty and skill attained here is quite comparable with those standards to which we are accustomed in individual child guidance therapy. Even in activity group therapy and play group therapy, both of which are very different from the traditional case work interviewing method, we have achieved such certainty. Continued close analysis of the group-therapeutic process in supervision and in seminars has enabled the therapist and supervisor at J.B.G. to have at any point of the therapy as exact a picture of the dynamic situation as we are able to get in individual psychotherapy.

This is really all one can demand from a new form of therapy and this degree of advance and success is entirely due to Mr. Slavson's untiring leadership against the natural inertia and the doubts of the case worker, whose resistance to acceptance of group therapy initially was considerable. Today, activity group therapy as practiced at J.B.G. is not only a workable but teachable method.

Dr. Hulse's lucid and stimulating paper, on the other hand, is very interesting because he attempts to crystallize, from quite a varied experimental experience of his own and of other workers, a number of practical general rules. I agree with much of his thinking, and yet it is extremely inviting to open a discussion on almost all of his points because, as it is with all practical rules on therapy there is none that cannot be broken, if one knows why and what for. Or, to express it differently: everything one does or everything that happens can be potentially useful in one, as it can be potentially unfavorable in another case. That explains why obviously sincere and astute observers and experimenters could arrive at apparently contradictory conclusions on technique. Dr. Hulse, himself, has not stressed this point, but I think he would agree with me. It might appear a hopeless task then to find one's orientation among all the proposed and differing suggestions on indications for group as against individual therapy, on thera-

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