GROUP PSYCHOTHERAPY -- A TECHNIQUE IN SEARCH OF A THEORY

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THE CONFUSION

The existence of a wide diversity of individual and group therapies which sometimes vary radically in their underlying conceptual and technical approaches is an extraordinary development in our field, and requires an explanation. The many solutions that are offered for the same set of problems, clearly indicate that the truth continues to elude us. Before the elucidation of the bacterial and of the viral bases of contagious illnesses, Man believed naively that supernatural forces caused most calamities, and offered tribute to non-existent deities which were believed to have been responsible for such tragedies. Dunglison's Dictionary of Medical Science (4.) published in Philadelphia only one hundred years ago states, under the term Contagion:

> "Contagious diseases are produced either by a virus called contagium...as in small-pox, cow-pox, hydrophobia, syphilis, etc., or by miasmata proceeding from a sick individual as in plague, typhus, measles and scarlatina...Physicians are, indeed, by no means unanimous in deciding what diseases are contagious, and what not. The contagion of plague and typhus, especially the latter, is denied by many."

Tuberculosis was non-existent then as a known medical entity, but its predecessor, Consumption or Phthisis Pulmonalis, is specifically mentioned as possibly being contagious, "but apparently without foundation".

The condition known as hysteria is also described:

> "...it received the name hysteria, because it was reputed to have its seat in the uterus...but it is not confined to the female: well-marked cases are occasionally met with in men... [it consists of] alternate fits of laughing and crying, with a sensation as if a ball--Bolus Hystericus--ascends from the

> hypogastrium towards the stomach, chest and neck, producing a sense of strangulation. The attack appears to be dependent upon irregularity of nervous distribution in very impressible persons."

The latest of therapeutic innovations for this psychiatric condition are also given:

> "...dashing cold water on the face, stimulants applied to the nose, or exhibited internally, and anti-spasmodics form the therapeutic agents. Exercise, tranquillity of mind, amusing and agreeable occupations, constitute the prophylactics."

Such certainty in the face of what we know now to have been blind ignorance should imbue us with humility as we expound our present day theories. For although mental illness is as old as other illnesses, the specialty of psychiatry as a scientific branch of medicine is relatively young. The state of the art in this specialty has, therefore, often been compared to that of general medicine two hundred years ago. Unanimity of opinion does not even exist about such fundamental questions as the nature of mental illness, many holding firmly that it is basically psychologic in origin while others dismiss such an approach lightly and concentrate instead on possible organic etiology. Some psychiatrists and psychologists consider mental illness a myth altogether, one that is used as a tool in support of The Establishment. Others regard mental illness simply as an expression of the Existential travail of Man.

It is understandable, therefore, that in this primitive state of affairs, many psychiatrists are discouraged and profess not to believe in the value of psychotherapy and, in fact, do not practice it in any form. The vacuum that was thus created by the professional bankruptcy of an important segment in psychiatry was rapidly filled by paraprofessional and professional, non-medical, therapists who have found the field

of psychotherapy not only personally satisfying but also economically rewarding. Their very entry into the private practice of psychotherapy and their continued existence as practitioners in the treatment of an illness is facilitated and made easier by the existence of a non-medical model as a treatment modality of mental disorders. Karl Marx (7.) observed as early as 1859, long before he became a poster and a banner, that "Men's social existence determines their values". In the light of this observation it is understandable why the non-medical model is being promoted and fostered even if it is confusing, and even if it obscures the all important basic fact that mental illness and emotional disorders are real, that they cause pain, chronic debility and death.

Not surprisingly, many non-medical therapists are no less perplexed than their medical bretheren in their understanding of psychotherapy, its logic and its mode of operation. Some fail to translate a theoretical understanding into a workable system, leading to therapeutic change. Such lack of clarity about psychotherapy in general is multiplied when the much more complex sub-specialty of Group Psychotherapy is considered. Several conscientious, honest and bright individuals have, nonetheless, laboriously constructed new theories from pieces of knowledge and then proclaimed their vision as being no less than the whole truth.

The situation is in many ways reminiscent of the famous story about the seven blind men who wished to discover the nature of an elephant. Their blindness prevented them from perceiving the totality of the beast, and instead, each was completely convinced, after carefully scrutinizing the part of the animal closest to him, that his description was both factually accurate and realistically correct. Such seven honest men must have been totally at a loss to understand how they could possibly comprehend the same animal in such totally divergent ways. To the extent that they

were free of unresolved personal conflicts and hostilities, they might at least have heard each other's description. With sufficient maturity and wisdom, such blind men would not a-priori dismiss as nonsense even descriptions that are basically different from their own perception. As we know, but they could not, all of those descriptions had some truth in them. They merely represented different aspects of the total picture.

If, on the other hand, the competitive nature of such blind men prevailed, or if each of them had a need to aggrandize himself as a discoverer of the whole truth, surely their entire project would have been doomed to utter failure. Freud and Lewin, Perls and Berne, Lowen, Janov and a few others would probably not have been able to listen and hear each other, had they had such an opportunity, and surely their partisan followers are totally incapable of doing so. Instead, complex theories are generally simplified, popularized, and held up by followers as the only truth, disdaining all others. It is probably safe to assume that each of the original contributors, from Freud on, would probably have disowned many of the practices that are so avidly proclaimed in their name by their followers. The historical moment may finally be at hand for us to try fitting the different parts into a whole picture.

THE PROBLEM

In the confusing field of psychotherapy, with the multiple claims made by its varied practitioners, the mere definition of the problems to be solved is a very real achievement indeed. An old, wise man of the East used to say that every good question contains important kernels of the answer within it. What constitutes mental illness and psychotherapy, and what are the basic assumptions and goals of such therapy?

Psychotherapy is therapy, the process of healing, of the psyche. The psyche is an abstract term coined to describe the mental functioning of a person. Psychotherapy, therefore, is the process by which the internal structure of the mental functioning of a person is changed, with the goal of making his or her life less painful and more satisfying and enjoyable. A mentally healthy individual is capable of working and enjoying himself without spending unreasonably excessive energy and without experiencing undue pain. The aim of psychotherapy is to help individuals reach such a goal. Those who wish to avail themselves of what psychotherapy has to offer come because they encounter seemingly unbearable difficulties in living their lives in a satisfying manner.

A very important factor contributing to the confusion that clouds our field may be found in the fact that patients present themselves with very vague and ambiguious complaints whose very identification and clarification is part and parcel of the psychotherapeutic process. In extreme cases, individuals do not even know that something is wrong with them, and consequently they do not seek any help at all, and may refuse it when offered. In less extreme cases, a person may no more than sense that something is wrong with him or her, yet, without an ability to identify, explain or even describe the nature of the difficulties. When the therapist is himself unable to recognize such vague complaints as symptoms of a real illness, he or she will tend to dismiss them as part of the Existential anomie or as part of the Crisis of our Time. In such cases, the despair and desperation of patients is only increased, since they feel once again that their call for help, even if clumsily presented, was again not heard, but explained away instead.

The field of psychotherapy is clouded with so much confusion also because the incidence and prevalence of mental illness is so great that <u>it</u>, and not mental health,

is the mode of our society. Mainly as a result of the urbanization of our society and the resultant breakdown of the family, ego development in the majority of individuals is impaired to a lesser or to a greater degree, and vague insecurity and anxiety is a most common occurrence. The drug culture and the widespread use of alcohol could not have existed otherwise.

Masked depression is by far the most prevelant, if generally unrecognized, illness of our society. Since therapists of all persuasions are also a part and a product of this culture, many of them are not personally exempt. It has repeatedly been demonstrated that therapists who themselves feel threatened by the symptomatology of their patients tend to gloss over and minimize such symptoms, or not see them altogether.

A few more basic concepts need re-defining and re-emphasis before we attempt to synthesize the various psychotherapeutic approaches into a single whole.

All psychotherapy, including group psychotherapy, is psychotherapy of individuals, not of groups. Group therapy is conducted in a group setting, but it is not the group that is sick, but the individual within it. The individual comes for help. It is he or she who suffers pain, or who has other difficulties when the internalized conflict has become characterologic. Group psychotherapy is, therefore, somewhat of a misnomer. Since the group does not have a psyche, it cannot be therapized. Groups have a dynamic existence, and individuals in a group behave and feel quite differently than they do otherwise. But the therapy is still and all that of an agonizing individual, and all theories of group psychotherapy that make any sense must, therefore, be derived from theories of individual therapy, and must be

extensions of such theories. The many failures of group psychotherapy and group treatment in its various forms may well stem basically from a failure to understand this simple but all important truth.

The hunger for closeness and for some form of meaningful human contact is so great in this society that all groups, whatever their underlying theoretical basis, have wide appeal, and individuals feel better for participating in them. But they frequently offer no cure, and the good feeling is short lived. The underlying illness is often not treated at all, the basic pathology remains unaltered and the patient reverts back to his or her pre-morbid self when the effects of the gratification are over. Such group experiences offer false hope and are analogous to benefits obtained from religious conversion. All ego-satisfying experiences are similarly helpful in the short-run. A happy love affair or the winning of a lottery can both be very helpful to a depressed individual. These, like the quick-cure, instant-intimacy group experiences are therapeutic. But they are not therapy. An aspirin may be therapeutic for brain-tumor pain. It is not therapy for it.

The mushrooming and frequent discovery of new "therapies" in our field appears to be a direct result of the widespread disappointment that both patients and therapists experience. The great promises of yesterday fall short in the light of today. It is as if each of the seven blind men has had a turn at describing his findings in a loud and clear voice before it becomes obvious that such a description cannot possibly coincide with the totality of the whole elephant. Psychoanalysis held not only dominant but almost exclusive sway for many years. While patients became psychologically wise and benefitted intellectually from very interesting insights, they often did not change characterologically enough to justify their great investments.

Sensitivity training and the encounter movement were largely a reaction against the barren and super-intellectualized approach of psychoanalysis. They assumed that the expression of feelings, here and now, in itself would be curative. Such assumptions have never been proven valid, and in fact the presence of thousands of freely emoting patients in back wards of state hospitals everywhere proves such an assumption to be without a base. Bio-energetic analysis, Gestalt and various off-shoots such as Movement, Poetry, Scream and Sex "therapy" made their claims in turn. The current vogue, T. A., often turns patients into "trainees" and eliminates their need to own up to the unpleasant and painful reality of having to seek help for an illness. The human growth movement can attribute much of its popularity to a similar appeal.

Whatever the label or the disguise, the populations in all these groups, including psychotherapy groups, have been found to be basically similar, and to consist of individuals in search of relief from emotional difficulties. It is only natural and understandable that people with pain would tend to gravitate towards those approaches that seem to hold the greatest promise for the quickest help at the least cost, both financially and in terms of suffering. As disappointment follows disappointment, public cynicism increases and the public image of psychiatrists and other psycho-therapists sinks to ever lower levels. Each successive wave of the then popular psycho-therapeutic approach seems to be shorter lived than the previous one. Psychoanalysis was accepted for several decades before its basic bankruptcy was recognized. The encounter and sensitivity movement were at their crest for only several years. The life span of T. A. is likely to be even shorter than that. Its simple-to-understand explanations of dynamic conflicts within the person are substituted for necessarily

painful working-through. Furthermore, when there is denial of the presence of an illness, there can never be, by definition, any hope for a real cure.

This public disenchantment with psychotherapy as a tool for psychologic healing is also shared by many psychotherapists. Some have attempted to show that the results of psychotherapy are no better than those achieved by spontaneious remission. A study of questionable validity to this effect is endlessly cited, quoted and brought up as proof by lay-writers and psychotherapists alike. Some bitter and disenchanted therapists have not only claimed,but almost seem to delight in the claim,that the long-lasting results of experienced and competent therapists are no better than those acheived by inexperienced therapists in training. Such studies, while possibly even true in their findings, have been cited not to prove the shortcoming of present day theory and practice but in order to justify the scrapping of serious psychotherapy altogether, in favor of "more promising" short-cuts. Some disappointed scholars have thus adopted a philosophy of psychotherapeutic nihilism, and gave birth to the anti-psychiatry movement within psychiatry. Since such psychiatrists and psychologists were unable to discover the basic defects of psychotherapy as it is now practiced, they have become social activists instead.

It is totally inconceivable to think of an anti-surgery movement among surgeons or of an anti-baking movement among bakers. That such a strange phenomenon is to be found in psychotherapy reflects the deep disappointment of many of its practitioners, as well as their shame and guilt at earning a living from an activity that to many seems to offer very little or no hope. Some therapists have even naively but seriously theorized that groups are therapeutic in themselves, and that the presence of a therapist is basically superfluous.

THE THEORY

And yet, it is possible to postulate a unified theory of group psychotherapy that would find an appropriate niche for most of the new and the old group psychotherapy approaches, and that would make coherent sense.

As claimed, a group might in itself have some limited usefulness in terms of helping isolated and frightened people socialize, and when used in a therapeutic context, is useful in releasing super-ego restrictions that might be damaging to an individual. The group can act as a benign and permissive parent, taking the place of a restrictive and less flexible one, thus providing support for a struggling individual who attempts to release himself from a punishing super-ego. But, as Durkin (5.), Spotnitz (8.), this writer (1.) and others have observed, the most important function of psychotherapy in groups by far is the provision of a forum for working-through of pre-oedipal hunger that is at the root of most depressions and other defects of the ego.

The concept of "Cure" in psychotherapy, not even recognized as existing by most psychotherapists, simply means a successful completion of the process of separation-individuation. A mentally well individual is basically as mature emotionally as he or she is chronologically. Feelings that emanate from unresolved needs of the past are often capable of swaying a person into actions that are no longer useful or justified by the reality of the present, but that are compulsively repeated. The therapeutic alliance with the therapist permits the patient to repeat within the transference the same conflicts that have normally hampered him in his other relationships, but to resolve them here more rationally. Traditional psychoanalysis holds that as the unconscious is made conscious, internalized conflicts are brought under the control of the ego, and as repressions are lifted the patient is able to deal more adequately with reality.

These basic concepts of psychoanalysis have proven true, but only in part. They provide a useful frame-work for understanding the psychotherapeutic process. But since language, a late development of the infant, is the basic or only means of communications in psychoanalysis, patients are often unable to work-through pre-oedipal hunger that results from disturbances in the mother-child relationship in the earlier, pre-verbal period. Wise and correct interpretations by the analyst may be assimilated by the patient, but often without producing the desirable character changes. As millions of disappointed ex-patients of old and new therapies clearly know, it is much easier to become wise to oneself and to one's self-defeating patterns than to gain the ability to extricate oneself from them. When the unconscious is made conscious the work in earnest just begins.

Sensitivity training and the encounter movement put the emphasis on the experiencing and expression of feelings in the here-and-now, this contrasting with the somewhat sterile and highly intellectualized exercise in self discovery represented by psychoanalysis. It was like a breath of fresh air. The highly cerebral involvement with the self in psychoanalysis was and is often used as a resistance against "getting in touch" with one's feelings, which frequently are painful. The new approach was invested with magic powers by its proponents. Since making the unconscious conscious did not heal, the "honest" experience and expression of feelings surely will.

It was no more than a short mis-step from such expression of feelings to the taking of license for acting on them and for "doing one's thing". Verbal productions alone, it was claimed, have basically failed in Psychoanalysis, gratification of repressed wishes was soon assumed to be curative, therefore. Such gratification

is generally enjoyable so it was convenient to ignore the fact that it is rarely, if ever, beneficial. Also ignored was the obvious fact that such gratification guarantees failure in achieving long-lasting results in psychotherapy, since no instrument remains for the difficult internalization of new modes of feeling and being.

The yearning for the unreachable mother is frequently not resolved in psychoanalysis and a depressive mood remains as a residue, since the relationship is not intensive enough to sustain the patient through the pain of mourning. The catharsis and gratification of infantile wishes that is found in encounter and sensitivity groups, as it often is found also in T. A., and occasionally in Gestalt and Scream Therapy, similarly leaves such yearnings in a permanently unresolved state, since a false promise of a reachable mother is allowed or even encouraged.

By grafting the more desirable features of the new "therapies" onto the psychoanalytic model, an intensification of the affective involvement of patients in the process of therapy is made possible. Deprivation of infantile needs remains a corner-stone of the process of working-through, since it builds up a head of pressure within the patient. For similar reasons, catharsis, which is pressure lowering, is best avoided. A therapeutic situation is constructed in which analytic neutrality is maintained, but not without the emergence of the therapist as a deeply involved, concerned and humane being. To achieve character-deep results the therapist must be willing and capable of being not only a transference figure but also a real one in the life of his patients, yet without encroaching on their freedom to grow according to their own values and inclinations, not his. In an Existential sense, what the therapist is, is no less important than what he does. The details

of his personal life remain unknown and obscure, his humanity does not.

Primal and other modalities of Scream Therapy (e. g. Casriel's (3.) that are designed to help patients "remember" early life experiences physiologically may also be incorporated into the basic model. As long as the scream is non-cathartic, it helps create a situation in which affective memory is released from the body tissues. The patient is aided in bringing his or her observing ego to the integration of such affective memories, thus helping to lift the repression. As Ellis (6.) observed, abreactive techniques are also used cognitively, and their abreactive element can be minimized. Bio-energetic analysis similarly attempts to unlock affect that has been converted into hidden bodily expression. It is a useful tool in an integrated psychotherapy system, helpful in releasing from their bodily imprisonment feelings that are literally incorporated. They can then become available for conscious working-through. Gestalt and even a few T. A. techniques are sometimes helpful in eliciting and intensifying the emotional experience of the patient in therapy, and as long as their limitations are recognized, may contribute to a successful psychotherapeutic outcome.

Any of the Old or New approaches, when used alone or as a panacea, are likely to allow patients to revert into becoming believers for a while, and eventually bring forth unnecessary and painful disappointment. Psychoanalysis and T. A. are especially similar in the sense that those who are involved with them often become a cult with an elaborate system of beliefs and values. The rigidly hierarchial system that is followed by the practitioners of both these "movements", contributes directly, if unconsciously, to such irrational and child-like adherence. Neither has proven very helpful in extending true conflict-free living.

In addition to all these, special techniques for intensifying dependency yearnings and other strong affects must also be introduced. Such techniques must aim at creating situations within the therapeutic setting in which well versed and well tested modes of being will no longer apply, thus making it necessary for the patient to resort to the use of previously unused modes of affective response. This temporary "knocking-out" of intellectual and other defenses is a requirement for the emergence of strong pre-verbal needs and fears. The situation thus created may well be termed a "Condition of Inapplicability". Although words may continue to be used, their symbolic, not their dictionary, value is what creates their impact upon the patients' psyche.

The aim of all therapeutic interventions on the part of the therapist in such a unified model of group psychotherapy is to apply a variety of psychologic techniques with enough impact to produce physiologic changes within the patient. Such changes, it is postulated, are necessary for real character change. Patients have been "driven crazy" sometime in the past. They must be "driven sane" in psychotherapy. The process is painful, like surgery, and patients normally use resistance to avoid making the trip. The group setting is the ideal one for applying such techniques. (1.)

The best, although not a perfect, model for the psychotherapy situation is the surgical theatre. It is a repulsive and frightening model to many therapists, even to some with a medical background, probably because many psychotherapists somehow err in feeling that surgery per se is inhumane. Bettelheim (2.) considered it important enough to write a book for psychotherapists reminding them that "love is not enough", possibly because of such misconceptions and prejudices.

The scalpel-wielding surgeon like the psychotherapist must, indeed, be free of personal hostilities that may interfere with his judgment, but both must have the courage and skill to "cut" into the live body of the patient to remove pathological parts that endanger his or her very existence.

It is absolutely essention that the surgeon, even more so than physicians in other specialties, be:

1. totally devoted to the task,
2. totally competent,
3. not involved in a non-objective, feeling or personal way with the patient, and
4. observing of strict surgical technique.

The patient, on the other hand, after carefully checking the qualifications of the surgeon, must decide whether he can trust his very life into the hands of this person, regardless of trepidations. The problem of trust in psychotherapy is more complex than that, but in either case, the patient has every right to expect both surgeon and psychotherapist to spare no effort whatsoever in seeing him or her through safely, even if this involves a great deal of inconvenience to the therapist. The commitment is a two-way affair.

The psychotherapist may remain no more aloof nor uninvolved than the surgeon can, and he cannot be neutral in terms of his caring for the patient. Psychoanalysts have often confused the need for analytic neutrality with at least apparent non-caring and aloofness. Unless the patient is a blind believer in a therapeutic system or in his guru-therapist, he would be prevented from getting more intensely involved if the therapist remained distant. The psychotherapist, like the surgeon, must also be more than just a compassionate human being, for it is not love but finely-honed skills that the patient needs to get well. In spite

of Bettelheim's admonishings, many guilty and incompetent, even if well-meaning, therapists fail to understand this basic concept. Good intentions, sincerity and humanism cannot take the place of clinical experience that sees through the defensive structure and knows how to deal with resistances.

Surgeons do not normally operate on individuals with whom they have important personal involvements, lest such emotional involvement interfere with the coolness of their judgment. Since the dangers and difficulties of the psychotherapeutic task are no lesser than those of real surgery, the psychotherapist, too, must retain enough personal detachment in spite of real involvement with his patient. This may sound most unacceptable and strange to those for whom terms such as "authenticity", "intimacy", "directness" and "closeness" have become rallying cries of a new cult. Yet, in psychotherapy pain is real and no anaesthesia is used except for the comfort that may be derived from reality, and from the reality of the relationship with the therapist. Unlike surgery, the patient is fully conscious and aware during the entire process, and must endure the pain that is incidental to growing, changing and giving up parts of the self.

The patient must never be deprived of the freedom which is truly his to change or not to change according to his or her own readiness for it, rather than out of a wish to please the therapist. He must repeatedly give permission to the therapist to be driven sane, even as fear stares him right in the eye. This is where the patient's trust in his own growing strength and the viability of the therapeutic alliance are put to the true test. The real joy of a therapist in seeing a suffering human being develop self-respect and a capacity and desire for self-fulfillment must not become a burden on the patient. It must remain a bonus that a therapist

must not count on but only welcome when it comes.

Finally, the psychotherapist, like the surgeon, must always remember that during many phases in the process of therapy the patient is extremely vulnerable to suggestions and to direct and indirect influence. Very much like patients in post-operative status so also in psychotherapy, vital signs must be carefully monitored for patients at that point are frequently unsteady and likely to undergo big changes suddenly. Newly found freedoms are sometimes used by patients without moderation before they can use them reasonably and without danger to themselves or to others. Antiseptic techniques are used to minimize surgical casualties, and similar meticulous caution must be used with patients in psychotherapy. What seems a minor fear or a small danger to the therapist is often regarded by the patient as being truly life endangering, or at least extremely frightening or embarrassing.

In effecting true character change the therapist, like the surgeon, must patiently but thoroughly separate that part of the patient which is his pathology from his healthy being, before attempts are made to cut it away. In more psychological terms, the patient's ego-syntonic psychopathology must be made ego alien before he can even consider giving it up. Infants frequently become panicky as they observe their bowel movement being flushed away, for they experience it as an important part of themselves which is being lost. Patients often feel similarly frightened and become resistant as they experience therapy as endangering parts of themselves that they have always considered important. Psychotherapists, even more so than surgeons, must be both sensitive and compassionate and yet quite firm and determined if they are to separate the patient from his emotional cancer.

THE PRACTICE

Theories are as valuable as they are verifiable in the real world. Such verification must be capable of duplication by independent workers, separate from each other and from the originator of the theory. These fundamental principles of the scientific method have been applied strictly in the natural sciences, and they are directly responsible for the spectacular advances in modern physics, for example. In the inexact world of the social sciences, on the other hand, wild claims are frequently made, since no clear formulations nor formulas exist that make the testing of such new theories both possible and feasible. Crisis Mobilization Therapy, C. M. T., is an innovative psychotherapeutic system that was recently developed and which incorporates the principles of an integrated model. It is presented here in outline form as a psychotherapy model that is testable against the theory. The value of C. M. T. is derived not from its newness but from its consistent integration of various elements and techniques into a workable whole.

Only a few points about C. M. T. need to be made in the context of this discussion. It attempts to re-create situations in the therapeutic setting that give patients an opportunity to re-experience their emotional conflicts at crisis points of maximum tolerable anxiety, and then bring their observing ego into the process of working-through. Various provocative and evocative techniques are used to overcome resistance which often is extreme.

The viability and strength of the therapeutic alliance is always being tested. The therapeutic work frequently occurs at the Point of Tolerance, and much skill, sensitivity and intuition are required on the part of the therapist to gauge correctly

the limits of such tolerance. He or she must refrain from exceeding such limits, for if the threshold is exceeded the patient will emotionally faint, block out all feelings or get confused, leave the room temporarily or leave therapy altogether, all representing a regression to the use of more primitive defenses. Others experience a temporary flight into health. Affect is mobilized and brought to a crisis point again and again, until it no longer assumes the dimensions of a crisis in the life of the patient.

Crisis Mobilization Therapy is an attempt to construct a psychotherapy model, most appropriately used in combined individual and group psychotherapy, according to principles that make theoretical sense. It may require modifications as our understanding of the intricate workings of psychotherapy expands and deepens. Yet, the fog of confusion is seemingly beginning to lift. A vague outline of a whole elephant is beginning to emerge. Its lines are likely to become sharper as we define more clearly the meaning of progress and the concept of cure in psychotherapy and in group psychotherapy.

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