TEN BASIC MISCONCEPTIONS ABOUT GROUP PSYCHOTHERAPY

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The true nature of group psychotherapy is widely misunderstood by the general public, by physicians in specialties other than psychiatry, but, somewhat surprisingly, also by psychiatrists and psychotherapists who may be directly involved. The misconceptions about group psychotherapy are so many in fact that the following list of ten must be regarded as no more than a sample. No single paper could possibly list and discuss all such misconceptions without becoming unduly long.

1. Group psychotherapy is good -- It's cheaper and useful in view of the manpower shortage.

When six or eight patients are seen together, the cost for each is clearly lower than if seen individually in intensive psychoanalysis or in psychotherapy. But this does not apply to most patients treated for emotional disturbances at any one time. Both the acutely and chronically ill are hospitalized and medicated, shocked or supported -- but not usually offered psychotherapy of any kind. The aim generally is to render psychiatric first-aid, and to restore them to functioning at the pre-morbid level. Group psychotherapy can replace medications and very expensive rehospitalizations only if it is frequent and long enough to change the patient's basic personality patterns, which undercuts the symptoms. Such intensive psychotherapy usually requires several sessions per week over a period of several years, and is as costly as most alternatives.

More importantly, the cost argument makes no more sense than the claim that aspirins should be administered instead of antibiotics, since the former are much cheaper. Well-meaning spokesmen for the public good who stress the almost universal need for help, promote group psychotherapy as the answer. In doing so, they ignore therapeutic considerations and clinical judgment,

and substitute sociologic and political reasoning in their stead. Promoting group psychotherapy on such unacceptable grounds probably serves more the interests of relieving the guilt of such advocates than it is in the service of the impaired and the sick.

Competent and mature group psychotherapists cannot be mass-produced, whether by governmental edicts or with the aid of large grants. In spite of all rhetoric to the contrary, the complex task cannot be learned in crash courses that "would meet the crying needs of millions." When so-called "group psychotherapy" is used to eliminate waiting lists, the real needs of distressed patients are ignored and the actual potential of this useful treatment modality is distorted.

Both patients and the discipline of group psychotherapy are used, abused and misused when false claims are made to obtain a desirable public image.

2. Group psychotherapy is good -- It helps isolated patients socialize.

Patients are frequently referred to psychotherapy groups even by experienced psychiatrists and psychoanalysts not only because they are short of funds, but also because they are lacking in human contacts and tend to live isolated and withdrawn lives. Membership in a psychotherapy group is expected to provide such scared individuals with a stimulus for greater human interaction and a model for social functioning. Many groups which represent themselves as psychotherapeutic do stress social interaction, but the actual work of psychotherapy has very different requirements. To do what needs to be done requires that patients not socialize outside the group setting, so that the difficult task may continue without hinderances. Even in the sessions themselves, other than the usual standards of social interaction apply. Patients are encouraged to speak the truth as they see it, and the assumption of social masks, behind which real character traits may be hidden, is dealt with as a resistance. Withdrawal and social isolation

are, in any event, only behavioral manifestations of underlying fears and defects in self concept. They are best not treated by developing social skills but by addressing the obvious difficulties with self-image.

Since these rather self-evident observations are surely also known to those psychiatrists and psychoanalysts who refer patients to groups with such reasoning, other, perhaps not fully conscious, motives must be the real causes for such referrals. These may, in fact, be last-ditch attempts to help extremely depressed patients and a tacit admission that they were not reachable in individual psychotherapy and psychoanalysis. A psychotherapy group is anything but a forum for practicing social skills. As patients' fears are lessened and general improvement occurs they coincidentally also feel more comfortable in social situations.

3. Group psychotherapy is good -- Everybody can learn to do it.

The lay-public, many psychiatrists and most non-psychiatrists somehow share in common the belief that group psychotherapy is a weak or diluted form of individual psychotherapy, and that, therefore, just about anyone can learn to do it. What is practiced under the label "group psychotherapy" is most commonly the direct responsibility of nurses, students, newly-graduated social workers and psychiatric residents. Senior and experienced psychotherapists engage only rarely in actual clinical work with patients in groups. Such individuals usually lecture, teach, supervise and direct, and the burden falls on the shoulders of the least experienced. Group psychotherapy is thus considered to be less important, less useful and less risky than the "real thing", individual psychotherapy, and suitable for novices. In non-medical settings, religious and occupational counselors, undergraduate psychology majors and even non-professional volunteers often conduct a variety of groups with a rich assortment of names. Although such

groups frequently disavow any intent to engage in psychotherapy, their main appeal is to sick individuals who refuse to accept the fact that they are in reality ill and need serious psychotherapy. Recovery, Synanon, Alcoholics Anonymous and many other similar self-help groups proudly contend that patients and ex-patients conduct their groups without professional help.

Group work, group counseling, Therapeutic Community Conferences and many other forms of group activity are commonly confused with real group psychotherapy, and even serious professionals tend to use these diverse terms interchangably, as if they were synonymous. Real psychotherapy in groups is relatively rare, and, instead, a rich assortment of therapy-like groups have mushroomed, and like dandelions, have taken over the field. Reflecting on the current scene, S.R. Slavson (1977), the father of group psychotherapy, writes: "sometimes I think I begat a monstrocity in initiating group psychotherapy." The programs of national and international group psychotherapy meetings clearly show that only a small number of papers and workshops are devoted to real group psychotherapy, while much attention and interest is centered on other forms of interaction in groups, not even remotely psychotherapeutic.

The following item appears in a special report to the American Psychiatric Association membership and dated May, 1977. "A steering committee to plan a national conference of the expressive arts therapies has begun to meet. The general goal of such a conference would be to identify, explore and seek solutions to problems that confront expressive arts therapists and psychiatrists who have special interests in art, dance, music therapy, group psychotherapy and psychodrama." In lumping group psychotherapy together with art, dance and music, its real nature as probably the treatment of choice for many

psychiatric disorders is not understood. It is considered to be, instead, one of several important, but fringe, approaches of psychiatry.

As such, acutely or severely sick patients are generally treated mostly with drugs, and the only available psychotherapy is offered in a group setting, almost as an after-thought. Such groups are regarded as doing at least no harm. In such a context it is understandable that the Michigan Psychiatric Society, for instance, recognizes child-psychiatry, forensic psychiatry, administrative psychiatry, adolescent psychiatry, geriatric psychiatry, psychoanalysis and research psychiatry as sub-specialties but it officially refuses to so recognize group psychotherapy.

Group psychotherapy can be a most enjoyable and rewarding form of practicing psychiatry, and some of the rewards, although not the main ones, are also financial. Why then are so few senior psychiatrists willing to practice it? The answer is probably to be found in the fact that the practice of good group psychotherapy requires an unusual amount of intuition and expertise, the ability to follow the dynamic developments of several patients concurrently, the willingness to be continuously exposed to the scrutiny of six or eight patients and the capacity to work under a great deal of stress. These requirements, by far more demanding and complex than those required in the practice of individual psychotherapy or psychoanalysis, competence in which is a prerequisite for the practice of serious group psychotherapy, have kept many psychiatrists, psychologists and social workers away. The field was left open for wild experimentations by semi-competent or wholly incompetent practitioners, for fools often rush in where wise men fear to tread. Well-meaning nurses and beginning students bravely engage in so-called group psychotherapy with very sick patients, while fully competent individual psychotherapists are hesitant and keep their distance.

4. Group psychotherapy is bad -- It is too difficult to do properly.

The argument that group psychotherapy is too complex and too difficult a subject to be mastered is usually proffered by those who themselves are too frightened by the challenges and demands of practicing it. Multiple transferences to the therapist and among the members of the group occur simultaneously, and such transferences are constantly fluid and in a state of flux. Monitoring and working with them requires an unusual degree of alertness, understanding, sensitivity and experience. The opportunities for failure in a group setting are by far greater than those in individual psychotherapy, as many psychotherapists have sadly discovered by experience. The challenges are both clinical and administrative, and the therapist who does not meet them promptly and properly is not only likely to be criticized but also to lose the patients and have the group disintegrate. With so many opportunities for error, the entire effort is often condemned, very much as the fox condemned the "sour" grapes. The basic faults that are said to inherently exist in group psychotherapy and which allegedly render it of little use in the work of basic character modification are best understood in this context.

This tendency to generalize rather than particularize deserves a special note for it is a widespread habit in psychiatry. Only professional arrogance can explain the use of such terms as "unanalyzable", as if general agreement existed about such judgments. Similarly, condemnations of group psychotherapy are often made as if they reflected universal consensus, when in fact they reflect no more than the limits of ability of those who make the statements. In discussing Dora's case, Freud was properly and honestly speculating about possible technical mistakes he had made, a habit not so arduously adhered to by all his followers. Leading theoreticians especially tend to generalize. Schilder (1938), for instance, says, "if one of the

patients tries to monopolize the situation, one has to turn to other patients. If the material brought forward by a patient is very archaic and shocking in character, one must give immediately an interpretation which will reduce the shock..." (underlinings mine, RBL). Schilder's words obscure the fact that he speaks only in his own name and expresses only his own views. The pronoun "one" imparts a false tone of universality. What Schilder considered shocking may not be so regarded by others, and his recommended therapeutic interventions may be in error, in spite of their authoritarian tone. Similarly, Foulkes (1964) wrote that at one point he believed that individual transference neurosis could not be analyzed in group therapy. Careful attention is required to realize that what allegedly can or cannot be done is often an expression of what one person, at one moment in time, is able to do. Foulkes himself, twenty years later, was prepared to withdraw his original statement. Lampl-de Groot (1967), speaking about "Obstacles Standing in the way of Psychoanalytic Cure" writes: "there are patients whose mother-infant dyadic relationship was so disturbed and engendered so much anxiety that one (!)(underlining mine, RBL) does not dare to go too deep into the primitive, chaotic inner-life." Such honest statements about the analyst's own apprehensions would always be more helpful if couched in less generalized language, for what is true for "one" is not necessarily true for all, nor for all time.

Group psychotherapy is indeed an extremely difficult and complex form of psychotherapy. The difficulties and challenges it presents are the reason why only relatively few practice it consistently and in earnest, while many only dabble in it. But, group psychotherapy is learnable, steps for acquiring expertise in its practice are clearly spelled out, and in competent hands it probably is the most effective psychotherapeutic modality for the treatment of many forms of mental illness.

5. Group psychotherapy is bad -- The lack of privacy prevents patients from dealing with embarrassing and difficult topics.

New patients commonly speak about difficulties they expect to encounter if they joined a group, since it is often feared as a semi-public arena. Such arguments are easily recognized as expressions of fear, analyzed, treated as resistances, and usually overcome without too much difficulty in a relatively short period of time. When these same arguments are advanced by therapists, they are usually garbed in theoretical constructs and complex language, but here, too, fear usually shows through.

Many senior psychiatrists, psychoanalysts and non-medical psychotherapists are uncomfortable in social and professional situations which require some degree of self revelation. This in spite of personal and training analyses and previous psychotherapy for themselves, during which not enough of their own fears have been worked-through. Rather than look at such a painful and unpleasant reality, the claim is made, instead, that embarrassing and difficult subjects simply cannot be dealt with in a group psychotherapy setting.

In view of such confusion the obvious and self-evident needs to be spelled out briefly: all subjects without exception can be worked through in properly conducted psychotherapy groups, specifically including matters of money and sex, homosexuality, murderous and libidinal fantasies, masturbation, incest, sadism and masochism and all bodily functions. The psychotherapist who is himself uncomfortable with these or any other subjects conveys his ambivalence to patients who are understandably reluctant to experience feelings that are commonly associated with "forbidden" subjects, whether in the one-to-one or the group setting. When such secret and hidden ambivalence of the therapist is sensed by patients, it stiffens their reluctance and increases their resistances. Such patients will probably have serious difficulties working with such a therapist in whatever framework, although

some time usually passes before this becomes clear. The therapist's fears and doubts bring about the fulfillment of his prophecy.

Confidentiality, too, can be properly maintained in a group setting when therapists are clear about its meaning and about ways and means of enforcing it. In a busy private practice of twenty group psychotherapy sessions per week, confidentiality was maintained without major difficulties over a period of twelve years. The potential for infractions always exists and repeated watchfulness is always in order. When acting-out, in general, is not permitted, adherence to the principles of confidentiality can be successfully achieved without unusual efforts.

The problem of even minimal self-revelations was obviously one that Freud himself had never completely worked-through, as he openly concedes. Being constantly observed is stressful to anyone, more so to some than to others. Freud was sufficiently ill-at-ease under such circumstances that he adopted the couch as the preferred place for patients, positioning himself behind them during sessions. Many of his followers struggle with similar problems, and these, rather than the special circumstances of group practice are the real reasons for its unacceptability on numerous occasions.

A lack of comprehension of these issues is responsible for the oft-repeated argument that group psychotherapy is superficial, that, at best, it can remove symptoms, and that it is not a fit medium for modifying life-long character difficulties. Such statements may be true when group psychotherapy is improperly practiced, but they are not at all true for group psychotherapy in general.

6. Group psychotherapy is bad -- Free association is not possible and unconscious material cannot be worked with.

The basic rule, free association, is the main instrument of psychoanalysis for reaching and working with unconscious material, and many analysts are

baffled by the claim that the job of basic character modification can be done without it. Freud's dominant influence is such that to this day his way of practicing is still closely followed, as if more than half a century has not passed since it was introduced. Ego psychology and other important theoretical innovations have gained a foothold, but free association is still considered inviolate. The task of individuation is one that not only those labeled "patients" must complete if they are to gain the freedom to make independent choices.

Other means of recognizing and working through unconscious material exist in group psychotherapy, including greater emphasis on non-verbal communications. The work of one group member is often intense enough to elicit reciprocal reactions in others who then proceed to struggle with both conscious and unconscious conflictual aspects of their own personalities. This process is basic to the functioning of well-working groups, yet it is not often recognized as being analogous to the basic rule of psychoanalysis. While self-evident to experienced group psychotherapists, others often look in vain for the old and familiar landmarks in the foreign terrain, not recognizing the specially adapted instruments of group psychotherapy for what they are.

The group-as-a-whole is commonly experienced as either a good mother, supporting and nourishing, or as a bad mother, depriving and withholding. Being in a group often powerfully taps pre-verbal hurt, hunger and rage, since the multiple transferences and the strong rivalries in a well-run group often bring up conscious and unconscious material with greater intensity than in individual psychotherapy and psychoanalysis. Such material is repeatedly worked with in a variety of ways, depending on the theoretical convictions of the therapist.

7. Group psychotherapy is bad -- transferences are diluted and real transference neuroses do not form.

Disagreement about the intensity of transferences in psychotherapy groups started early. Slavson (1971), true to his own strict psychoanalytic background, claimed that such transferences are diluted and that real transference neuroses do not form in group psychotherapy. Although Glatzer and Durkin (1973) as well as several others have convincingly argued the opposite, Slavson's old position seems to have a persistent hold on the minds of many. Consequently, statements are made from time to time claiming that real character re-organization is not possible in a group setting, that the group is capable, at best, of removing superficial symptomatology, and basically, that group psychotherapy is less thorough than individual psychotherapy and psychoanalysis, and mainly palliative in nature.

In an article entitled "The Psychotherapy Group -- A Necessary Ingredient for Real Character Change", this writer (1977) shows in some detail that the very opposite is true. Accordingly, many individual psychotherapies fail to accomplish what they set out to do exactly because the dyadic setting limits the opportunities for intensive enough working-through of character defenses. Such defenses can be challenged more directly in a well-run psychotherapy group by the use of modalities that are inappropriate in the one-to-one situation. Original conflicts can actually be re-experienced in a group with full intensity when proper technique is observed, and fully developed transference neuroses are practically unavoidable within the proper theoretical framework. Crisis Mobilization Therapy, C.M.T., is one such model. Transference neuroses are routinely present, so intense, in fact, that in borderline patients they frequently include momentary lapses into transference psychosis. Patients undergo physiologic changes as they go through such powerful experiences, a requirement for real working-through (Bar-Levav, 1976 b).

Since the personal experiences of the majority of therapists do not include therapeutic moments of such intensity, some may even suggest that the foregoing claims are exaggerated and do not in fact exist. What happens more commonly in psychotherapy groups is explanation, interpretation, advice, and the giving of solace and support, and with these, indeed, a transference neurosis is not likely to develop.

In combined individual and group psychotherapy situations such as Crisis Mobilization Therapy, patients usually prefer individual sessions to the more challenging, frightening and affect-laden groups. Their life-long character defenses are repeatedly challenged in the group, in a process that is often painful and unpleasant. The exclusive attention of the therapist which is available in the one-to-one setting is never so fully available in the group, giving rise to jealousy and competitive strivings, and eliciting pre-verbal hurt, hunger and rage. Patients often experience themselves in the group as vulnerable and exposed, and levels of anxiety are purposefully raised to minimize intellectualization. The group session, not the individual one, is the focal point of the working-through process. Individual sessions exist mostly to strengthen the therapeutic alliance and to shore-up any cracks in it by making coherent that which has been stirred up in the group. Without individual sessions patients would often not tolerate the pressures of therapy in groups which challenge life-long modes of being. The group is essential for real character change. Without it patients might feel better, but they would never get well.

8. The more interaction in the group the better.

The assumption that the more interaction in the group -- the better, is widely accepted but has never been proven valid. In fact, interaction often replaces painful introspection and self-confrontation, and it thus can serve as a resistance to real personality change. This simple-minded assumption is, nonetheless, so commonly held to be true that it is used as one of the

standards of evaluation for workshops presented at meetings of the American Group Psychotherapy Association. The freedom to interact in a group indicates a relatively low level of anxiety. This apparently being a desirable goal, interaction has become a gauge of the group's health.

But, intrapsychic changes do not occur in a vacuum. Objects and forces in nature tend to remain at a state of rest and to maintain the status quo, and all shifts and changes involve work and pressure (Bar-Levav, 1976 b). Laboratory studies as well as clinical observations show that internal shifts within individuals are also the result of pressured choices, and these are usually associated with relatively high levels of anxiety. Working-through in Crisis Mobilization Therapy takes place at the highest level of tolerable anxiety, before patients either bolt from therapy or present resistances that cannot be overcome. Such relatively high levels of anxiety are designed to maximize pressure in the direction of change. Social situations, on the other hand, are aimed to be as anxiety free as possible to promote smooth interaction. Patients understandably also prefer such conditions over the anxiety-laden tension that is an inseparable part of working with painful unconscious material. For obvious reasons they prefer interaction or silent withdrawal, yet both clearly interfere with progress in therapy. The high value accorded interaction by AGPA and others is an indication of the primitive state of development of group psychotherapy, and points out the urgent need to determine what really produces progress and cure in psychotherapy. No reasonable explanation exists for the strange assumption that interpersonal activity produces intrapsychic change or real shifts within the personality.

9. Feedback is curative.

In the absence of a generally acceptable theory of group psychotherapy, fads follow each other in rapid succession. One of the most recent, persistent

and popular ones is modeling human mental functioning after that of a computer, a self-correcting system that is programmed to respond to feedback from the environment. This totally incorrect choice of model completely ignores the all-pervasive forces of unconscious motivation as continuous interferences with the more objective determinants that guide human behavior. The model has already corrupted our language. Time was when we spoke of reactions, impressions and observations that people have in relation to others, such terms emphasizing the subjective nature of such productions. Nowadays, many psychotherapists and others prefer the computer term "feedback", which they deem to be more scientific and sophisticated. The hidden implication of using such non-human terms is that they represent degrees of objectivity that, in fact, they do not possess.

Feedback is the term often used in psychotherapy groups when subjective reactions are asked for about the behavior or verbal production of an individual. Such "feedback", under the guise of asking for objective, and, therefore, true representations of reality, is frequently used to pressure patients to conform to the acceptable mores of the group or the therapist. What many group members and/or therapists claim to be true is "validated" by "feedback", which often serves as the enforcer in the name of objectivity. Insistent nudging by several individuals is usually successful in frightening a person into submission and into an outward acceptance of the concensus. Refusing to change under "feedback" pressure is to risk social exclusion, generalized disapproval and isolation in many groups. Although such an approach is obviously anti-therapeutic for it discourages individuation, it is not often enough recognized as such, even by senior professionals. Yalom (1970), for instance, lists "imitative behavior" as one of several curative factors.

The philosophic assumptions of an approach that defines truth in terms of acceptance is totally foreign to Western thought and to the scientific method. The group, according to this model, is primary, not the individual, whose values or welfare may be sacrificed for group cohesiveness, "cooperation" and apparent harmony. Social acceptability is placed above self acceptance, and it is, therefore, basically a harmful and pathogenic approach.

10. Individuals are cured by "treating" the group as a whole.

As stated elsewhere,"Psychotherapy is therapy, the process of healing of the psyche. The psyche is the abstract term coined to describe the mental functioning of a person. Psychotherapy, therefore, is the process of healing and changing the mental functioning of a person in the direction of health, with the goal of making his or her life less painful and more satisfying and enjoyable. "...Group psychotherapy is psychotherapy of individuals, not of groups. Group psychotherapy is conducted in a group setting, but it is not the group that is sick but the individual within it. It is he or she who suffers pain," or who has other characterologic difficulties....

"Group psychotherapy is, therefore, somewhat of a misnomer, since the group does not have a psyche, nor internalized object representations...therapy is related to 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" (Bar-Levav, 1976 a).

While the Tavistock, group-as-a-whole model, often associated with Bion, Ezriel or Foulkes has had little acceptance in the U.S., perhaps because of its extreme position that ascribes to a group an ego, a super-ego and a mind all its own, many group psychotherapists assume a middle of the road position. Unable to accept the group as the patient, a living entity that supposedly "reacts", "feels",

"thinks" and "expresses itself", such therapists also reject the opposite position that group psychotherapy is, strictly speaking, a misnomer. In an eagerness to be fair to all, our society places high value on compromise positions, as if lukewarm is always best.

Borderline patients and others having difficulties because of diffuse ego boundaries and identity confusion are easily harmed when "the group" is treated, rather than each individual within it. The number of people seeking help for such difficulties is steadily increasing, and for them statements such as "the group feels" are likely to increase the turmoil. Moreover, the push to individuate is decreased for all patients by such an approach, which permits the avoidance of individual responsibility as well as hiding in the generalized group cloak. Such hiding is directly in the service of resistance to individual character change, and since it makes an escape from the tedious task of working-through easier, it serves as a hinderance to progress in psychotherapy.

Each of the ten listed misconceptions deserves a separate and full discussion, and so do several other important misconceptions about psychotherapy groups that have not even been mentioned. All deserve urgent correction to minimize pain, the wasting of time and the wasting of life.

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