THE GROUP-AS-A-WHOLE APPROACH: A CRITICAL EVALUATION

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Editors' Summary. The basic philosophic assumptions of the group-as-a-whole approach are analyzed and its history is traced. The fate of the therapeutic alliance when faced by the peculiar requirements of the group-as-a-whole approach is examined. This is also done with regard to real and transferential relationships. Against this background, six advantages and disadvantages of this group therapy model are discussed.

Although he points out some of its merits in engaging patients in intensive work relatively early, the author maintains that the use of this model seriously interferes with the patient's ability to individuate. It is thus felt to be essentially counterproductive except for the purposes of short-term demonstrations and teaching.

Preferences and loyalties are generally determined by chance. We cheer the sport team of our town or school, and would probably cheer the opposing team with equal enthusiasm, but for a few chance associations in the past. Tastes in music and food are similarly fixed by previous exposure, and even value systems are rarely chosen freely. Basic components of values reside in the superego, and unless its hold has been released through personal psychotherapy, what we believe in tends to resonate the fears and preferences of those who were most influential in shaping our personalities.

It would be surprising if the same did not also apply to some of our professional convictions, especially in areas where knowledge is incomplete and hypotheses are not easily proven or disproven. Our psychotherapeutic models are usually compatible with those of our training institutes, since professional identities reflect encounters with respected teachers and senior colleagues. Critical scrutiny and change are not easily come by.

In the absence of a generally accepted body of knowledge about the etiology and pathogenesis of mental disorders, much of psychotherapy and group psychotherapy continues to grope in the dark. Since we cannot yet all agree on what needs to be done, we obviously are also unable to agree on how to do it best. In the face of much uncertainty, clinicians understandably tend to hold on tenaciously to that which they know best. In this paper I will try, therefore, to state assumptions that the reader may agree with and derive conclusions based upon them alone.

THE THERAPEUTIC ALLIANCE REEXAMINED

The efficacy of the group-as-a-whole in the treatment of emotional illnesses of individuals must be evaluated from the perspective of what we wish to achieve. Patients come to therapists with acute distress, and understandably are looking for quick relief from their suffering. Long-term, reconstructive psychotherapy aims, however, at more than simply minimizing pain. The goal is to effect major shifts in the patient's defensive structure (as reflected in his typical modes of being), thus lowering the likelihood of recurrences, and effecting a cure.

How is the goal achieved in psychotherapy? The corrective experience occurs within the psychotherapeutic relationship, which provides a forum in which the patient may reexperience frightening affects in a safe environment. The therapeutic alliance between the patient's healthy ego and the therapist enables the patient to risk reliving nightmares of the past, because his own adult resources and the reassuring presence of another provide security. The repetitious reexperiencing of the old horrors in a setting that puts them in realistic perspectives eventually saps them of their crippling grip.

The development of an intense therapeutic relationship is, therefore, a precondition for success in psychotherapy. Involvements which lack the strength to hold patients in place even when they feel their experiences as life-threatening result in interruptions of therapy before termination. *In the absence of a sufficiently intense involvement, patients at best examine, but never dare to experience, their most profound fears.* Such therapeutic situations increase the scope of understanding, but they fail to produce real personality change. Even well-trained and well-qualified psychoanalysts and psychotherapists sometimes forget that reasoning with patients is useless and counterproductive, and that the emotional correction must take place within the relationship and not within the cortex. The task is, therefore, never seriously undertaken before patients are completely convinced that the therapist is really reliable and trustworthy, and that he will not desert them at the moment of their greatest fear. This is a necessary intermediate step before they discover their own resources as reliable and trustworthy.

THE REAL VIS-A-VIS THE TRANSFERENCE RELATIONSHIP

The enormous fears that cause patients to repeatedly test the reliability, commitment and sanity of their therapists are never overcome by diplomas or by formal reassurances. Both consciously and unconsciously patients hope to discover an Achilles' heel in the therapist, which will provide them with a valid excuse to leave the fear-filled situation. The *real* qualities of the therapist are, therefore, of utmost importance. While transference distortions occur in all relationships, and they are especially likely to occur in relationships to therapists,

transference neuroses of sufficient intensity will usually not develop, unless the therapist proves himself *in reality* to be reliable, steady and free of major distortions of his own.

Slavson (19) and others have held that the transference neurosis in group psychotherapy is always diluted as compared to individual psychoanalysis because (in their experience) no one can expose his or her innermost self, nor allow the experience of embarrassing and frightening affects. Like so many other controversies in psychotherapy, this disagreement is also perhaps best understood in the context of the personality of those who are taking part in it. Slavson, like many others having been raised with basically different mores and values from those prevalent today, understandably regards the revelation of parts of the self in a group impossibly difficult. The group is experienced as less safe than the dyadic setting. The fact that Slavson had fathered many central concepts of group therapy and argued its usefulness is obviously of little relevance. Whatever the source, statements about the intensity of the transference neurosis in the group must be checked against the emotional background of those making them if we wish to increase their objective validity. (The very definitions of normalcy and psychopathology and the boundaries between the two often contain, in fact, cultural determinants, and they frequently represent individual subjective expressions, tolerance or intolerance, comfort or discomfort, with various modes of being. Szasz goes as far as citing this as proof for his assertion that mental illness is but a cultural myth. In reality it points to the urgent need to objectify and scientifically validate the etiology, pathogenesis and naturaly history of the illnesses that are treated by psychotherapy.)

To the extent that aspects of the therapist's real personality are indirectly revealed as the work proceeds, patients gain reassurance or get frightened, and these have direct implications for the continuation of therapy and for the intensity of the transference neurosis. The greater the opportunities for observing the therapist as a real person in terms of his trustworthiness, the more clearly can one determine how much of a patient's holding back is transferential. As transference distortions are worked through, intense transference neuroses will develop when the reality of the therapist as a person justifies it. The group setting provides many more opportunities for self-revelation by the therapist without disclosing biographical material, since he cannot but give off clues about his real self as he involves himself in his task. Patients carefully watch such traces and clues, and can do so best at moments when they are only passively involved with the therapist, for their anxiety is usually lower then, and their observations more astute as a result. If the therapist proves himself to be basically trustworthy in reality, this always maximizes the chances for the formation of intense transference neuroses.

The position of the analyst in classical psychoanalysis, on the other hand, is one of basic anonymity, based on the unproven belief that this facilitates the

formation of a transference neurosis which most accurately reflects the pathological conflicts and life-styles of the patient. Therapists in the group-as-a-whole approach basically follow this model, using the same reasoning. While revelations of personal, statistical or biographical data about the therapist tend to limit the patient's freedom to distort him transferentially, it is becoming increasingly evident that lack of clarity about his real qualities as a person is generally used as an understandable (and justified) resistance to real involvement with him. (This, unfortunately, is what many analysts and therapists unconsciously desire, for it maximizes their comfort. The choice of therapeutic model, like all other important choices, is obviously not free of overdetermined components.)

The intensity of the transference neurosis is probably indirectly related to the patient's fears and transferential distortions, and directly related to his perception of the therapist as a trustworthy person in reality. It is of greatest importance, therefore, to provide patients with chances to observe the therapist repeatedly as a committed, caring and essentially fair human being. The relative absence of such opportunities in psychoanalysis and individual psychotherapy may well be the factor that limits the intensity of the transference neurosis. Therapeutic outcomes of "successful" courses of psychotherapy or analysis which frequently leave much to be desired in terms of real personality change may perhaps be explained by such an attenuated quality of the transference neurosis. The group, in which therapist exposure without deliberate self-revelation takes place, may well be a necessary component of any successful psychotherapy, without which even the most sincere and dedicated efforts are bound to yield only incomplete results (4).

How intense is intense enough? What yardstick do we use to measure it? One's capacity to recognize desired states of intensity in a realtionship is, obviously, determined by the degree of one's comfort with intimacy in general. Freud created the psychoanalytic setting for his clinical endeavors in an image that fitted his personality and the limits of his tolerance. As his brilliant descriptions show, his patients improved, but they never worked through their preverbal hunger and rage. The most important areas of their pathology were consequently left untouched, and the basic, core depressions were not lifted. More recent clinical experiences show that patients must repeatedly relive the entire *feeling experience of early infancy with an intensity that involves important physiologic parameters* to unblock and reverse the effects of subjective experiences and traumas that interfered with their normal personality formations. Reexperiences in adulthood of events which were felt as endangering the very survival of the infant long ago are, nevertheless, still experienced as extremely dangerous. Patients always try to avoid them. And yet, only through actual reexperience can one really know that even the worst subjective fears may not in reality be objective threats.

The therapeutic alliance and the therapeutic relationship are of sufficient intensity when patients repeatedly dare to experience murderous rage and seemingly consuming yearnings *in relations to the therapist* without terminating therapy or acting-out. This is not achievable unless the patient knows from personal testing that the therapist is trustworthy, reliable and fair in spite of all the transference distortions that the patient attaches to him simultaneously.

In the group-as-a-whole model, opportunities for ascertaining the true qualities of the therapist through direct observation of his mode of being in the group setting are wasted. The unavoidable shortcomings of the psychoanalytic and other dyadic settings are transplanted, as if they were totally desirable.

THE GROUP-AS-A-WHOLE IN HISTORICAL PERSPECTIVE

The important work of Foulkes, Bion, Ezriel (7,8,9) and others in adapting classical psychoanalysis for use in a group setting arose out of their wish to improve on the practice of individual psychoanalysis which, all too often, seemed to fail in effecting real personality change in patients. A great deal of integrity and daring were required to break away from old molds, as Grotjahn (11) recognizes in his tribute to Foulkes:

> He had the courage to unlearn what he had learned in his analytic training . . . his courage to be independent in his inner-freedom, to observe and think are astounding to anyone who grew up in similar circumstances and has had to struggle with residuals of this background.

We can but speculate on the inner struggles of these pioneers, who admired Freud and accepted many of his teachings while repudiating important elements of the therapeutic system built upon them. The basic rule of free association and other techniques of individual analysis could obviously not be directly transplanted to the group setting. How then would they counter the sharp criticism of former colleagues for abandoning tools useful in working with unconscious material? They would attempt to modify rules based on their previous traditions and old assumptions, and apply them in a setting more useful to their patients.

The search was limited by the terminology of psychoanalysis and by its basic assumptions. In working with groups they did not abandon the traditional position of psychoanalysis that the therapist remain both neutral and relatively anonymous. The benefits of limited self-revelation were not understood, nor did they fit their typically German and British reserve and personality styles.

Freud's article on "Group Psychology and the Analysis of the Ego" was written in 1921, long before the development of the group-as-a-whole approach (10). But neither in this article nor in subsequent writings did he comprehend the complexities of the therapeutic situation in the group, and concepts such a

lateral and horizontal multiple transferences and the use of co-therapists had not been addressed at that time. The search ended in a bold and imaginative fashion when the group itself was ascribed an ego, superego and a mind all its own. In the absence of a separate and comprehensive theory of group psychotherapy, this was an understandable and expected development. The assumption that groups are also comprised of the same psychic structures as individuals made it possible to regard them as analogous for therapeutic purposes. If groups could be treated in a similar fashion to individuals, a real break with traditional psychoanalysis would not be necesary. The psychoanalysis-in-a-group model of Wolf and Schwartz (21) was not yet available and, in any event, in the eyes of the British pioneers it would probably resemble too closely the original product which was found to be inadequate. The group, then, was treated as if *it* were the patient, a living entity that supposedly "reacts," "feels," "thinks," and "expresses itself." It was assumed that in such a therapeutic framework individual repressions would be lifted, the unconscious would become conscious, and the elusive cure would be found.*

SOME ADVANTAGES OF THE GROUP-AS-A-WHOLE MODEL

It would be both untrue and unfair to claim that those who adhere to the group-as-a-whole model do so solely for historical reasons. This approach has several distinct advantages, especially in those rare instances when the model is adhered to without compromise:

1) Group formation is enhanced and speeded up when a number of individuals meet for a group psychotherapy session with an anonymous or relatively passive leader. The universal search for certainty and for structure is immediately frustrated, directions that are generally sought are not given, and useful anxiety is generated. This is in sharp contrast to the many approaches in which therapists aim at making patients "feel good." As long as the anxiety does not exceed the point at which patients withdraw, act out or leave, it provides the head of steam that propels the psychotherapeutic effort. The apparent absence of leadership tends to bind disparate individuals who share the same difficult situation, and it forces them to fall back upon their own resources. The typical ways in which individuals react to such stress soon become evident.

2) The continued efforts to engage the therapist and the frustration of these efforts eventually elicits preverbal hunger and rage which then becomes available for working-through. Intense transference reactions (not necessarily transference neuroses) are likely to develop early. If, somehow, patients can be prevented

*The validity of these basic assumptions of psychoanalysis and of dynamic psychotherapy have only been questioned in earnest by a very few, such as Rosen in his Direct Analysis, Spotnitz in Modern Psychoanalysis, Lowen in Bioenergectic Analysis, Perls, Janov, Rolf and this writer in his Crisis Mobilization Therapy. (18, 20, 14, 15, 13, 17, 2)

from quitting therapy under such conditions (which is highly improbable unless the basic model is compromised*), intellectualizations, explanations and evaluations, all relatively useless, are minimized. The essential work of psychotherapy, the working-through of character defenses and resistances, can begin without excessive delay. In this sense the group-as-a-whole model is refreshingly efficient when compared with most "innovative" group "therapy" approaches in which the "leaders" are very careful not to antagonize or alienate patients, unconsciously seducing them into a relationship which is of little value.

3) The journey of psychotherapy begins in earnest when issues of control are first encountered. When patients express archaic or infantile wishes or wants, "needs" or demands, and when these are not satisfied, or when gratification is delayed—only then is the strength of the relationship first tested. This is the end of the "honeymoon" when patients often begin acting-out or leaving therapy, claiming sudden magical cures. Many therapists, both in individual and group settings, unable to handle such difficult situations, consciously steer away from such dangerous waters as long as possible to the detriment of their patients. In the group-as-a-whole, on the other hand, such avoidance is not possible, for when the model is strictly adhered to and individual demands are dealt with only in the context of group interpretations, frustration, despair or rage is elicited without much delay. When the patient is unable to control the therapist with reasonableness or with expressions of helplessness or hurt, the rage of impotence which is universally experienced in early infancy cannot be avoided. These strong reactions are obviously very useful in the process of working-through.

THEORETICAL OBJECTIONS TO THE GROUP-AS-A-WHOLE MODEL

The group-as-a-whole model has been criticized because of its theoretical weakness, not only by those who reject group psychotherapy altogether, but also by clinicians who recognize the group's usefulness as a therapeutic modality and who accept basic psychoanalytic assumptions. Such criticism emanates both from empirical, clinical observations and from a theoretical examination of the model's focus. It is claimed that this approach addresses itself clinically to the wrong entity, the group, rather than to its individual members, and such focusing is, furthermore, claimed to be an unnecessary modification of individual psychoanalytic technique. Redl (16, p. 74), who together with Eckstein pioneered the applications of psychoanalysis to work with children and adolescents, points out that:

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*Horwitz (12) points out that the "effort to transpose a classical psychoanalytic individual situation to a group setting seems unduly frustrating for the patient." Extreme deprivation of infantile wishes for gratification can, however, be achieved without endangering the continuation of therapy when the transference is split.

> When "group emotions" are discussed, it is realized that they do not occur in a vacuum, but they are events that take place within and among the persons who constitute a group . . . The term "group" does not seem to designate some special quality, but rather, the "conditions for their arousal." Thus by "group emotions," the reference shall be made to instinctual and emotional events taking place within persons under the pressure of group . . . processes.
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> Not all of the emotion people have while they are in the group is really "group" emotion. . . . Not all group emotions are equally *basic* to the process of group formation. . . . The adoration one hundred people have for one and the same person make this person their leader. It is basic for the formation of the group. On the other hand . . . a number of other emotional relationships may develop between these persons.

Bar-Levav (3, p. 134) assumes a similar but more unequivocal position:

> 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 individuals within it. It is he or she who suffers pain, or who has other characterologic difficulties. . . .
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> 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.

Wolf and Schwartz (21) have, indeed, attempted to do just that. Their contributions were based on the conclusion that effective psychoanalysis of individuals in a group setting was possible and that it did not even require the basic modifications that the English school believed it needed. They held that the usual analytic procedures were fully applicable in the group, specifically including free association, which was simply redefined as including all the interventions of group members during the session. In their view, the stimuli provided by the group enhance and facilitate the usual psychoanalytic process and provide it with additional force and impact.

These theoretical objections have far-reaching implications for actual clinical practice. These will be discussed next.

PRACTICAL DISADVANTAGES OF THE GROUP-AS-A-WHOLE MODEL

The missed opportunities for observing the therapist as a real person when the holistic model is followed have already been discussed, and its undesirable effects on the formation and intensity of the transference neurosis have been reviewed. Five other major disadvantages will now briefly be outlined:

1) When the group is exclusively treated as a whole unit, differences among its component parts must, by definition, be ignored or at least are not directly

addressed within the group. As Bales (1) has demonstrated, small groups always serve as arenas in which the tensions of individual members are built up or "bled-off," so that one equilibrium after another is established in a long, repetitive cycle. "The dilemma of all action systems is that no one disturbance can be induced without creating another." The levels of satisfaction of each member of the group, his subjective evaluation of how profitably he spends his time and money will vary from one person to another, not only because of different interventions from the therapist, but even more so because of the individual's own needs and expectations. When the group is treated as a unit, all such differences among members must be ignored, even though, in fact, they provide important clues about each member's typical life adjustments to internalized conflicts. For example, by not permitting smoking in my practice, I consciously, if reluctantly, give up the use of one indicator of my patients' oral needs. When all individual indicators are overlooked by design, even obvious resistances and self-defeating maneuvers must be left untouched.

Horwitz (12) correctly points out that when the holistic approach is strictly applied it severely restricts the therapist who "becomes a prisoner of his method." Rivalries and jealousies among group members are obviously not eliminated simply because one theoretical model is chosen over another. When addressed only through group interpretations, opportunities for detailed working-through of such conflicts are minimized or missed altogether.

2) When a therapist tells a patient at the beginning of analysis that he will speak only when he has something significant to say, more than a neutral explanation about the technique of therapy is conveyed. The patient is being programmed to ascribe significance to any and all of the relatively infrequent utterances of the therapist. Although it may be useful in intensifying the transference, it is a contamination that must be worked with consciously if the patient is not to be abused. Similarly, the long silences and the infrequent group interpretations of the therapist in the group-as-a-whole often cause patients to ascribe a heightened significance to his few words. These are often interpreted and given hidden (and often distorted) meanings, as if they came from an oracle. Since therapists in this model usually speak only after a long period of observation, "when the therapist has been able to diagnose the common group theme" (9) and a comprehensive interpretation can be made about the "group structure"—such words are not easily questioned, whether right or wrong. Shades of meaning that may or may not have been present are often pondered upon at much greater length than they deserve. When such powerful words are heard as critical, they tend to have an inhibitory effect on future productions and expressions. Such exaggerated power positions of therapists play into the self-deprecatory tendencies of their patients and inhibit their efforts towards autonomy. Conflicts that are reactivated by the group are often re-repressed. The individual patient's constant inability to engage the therapist in an open challenge may elicit useful preverbal rage, but such rage must be worked with individually in order to have

therapeutic value. Failure to address it specifically tends to reinforce pathologic defenses and repression.

3) Borderline patients especially, but also those with other diagnostic classifications, feel tremendous anxiety when they experience another person as exceeding the customary distance which they maintain with others, and which they believe to be safe. Social or emotional isolation is a characteristic finding in many forms of emotional illness, but *all* individuals fear contact when they experience it as too intimate and as threatening the integrity of their ego boundaries. One of the major tasks of reconstructive psychotherapy is, therefore, to alter the subjective experience that safety is achievable only at distances greater than required by reality. The panic-producing threshold of the fear of merging or the fear of being swallowed is different for each individual, but it must always be addressed at the threshold level if the boundaries of safety are to be expanded. Exquisite timing and a great deal of individualized attention are required with each patient if this goal is to be reached. Such individual work is not possible when all interventions are addressed to the group-as-a-whole.

The group setting is often itself frightening and confusing to those with diffuse ego boundaries who experience the stimulation of the process as very disturbing and threatening. Unless repeatedly addressed before individual anxiety thresholds are exceeded, the group's usefulness ceases to exist for patients overcome by such fears. Patients sometimes even tend to deteriorate in a group setting in which such fears are ignored. The limitations of the group-as-a-whole model in such cases are self-evident.

The recent interest in borderline states probably signifies no more than greater skill in diagnosis, since, just as in Freud's day, this probably is the commonest form of psychopathology. A therapeutic model that fails to address itself to specific fears of such patients may be dangerous to those who, at first, seem healthier than they actually are, and who may be placed in a group before the full extent of their illness is obvious.* Many of the dropouts from psychotherapy groups conducted according to this model may well experience their leaving as an act of self-preservation. Such groups may in reality be unsafe settings for such sick individuals.

4) Acting-out is a common and a dangerous form of resistance that must be firmly controlled if psychotherapy is to achieve a successful outcome. Since acting-out is always related to an individual's anxiety threshold and since it often tends to masquerade as reality, special and diligent efforts are necessary to distinguish between simple actions and emotionally charged acting-out. Such common forms of acting-out as lateness, non-attendance of group sessions or delay in the payment of fees may require minute examinations of details to determine where reality ends and where resistance begins. Such scrutiny is best

*A combined approach of individual and group psychotherapy with multiple therapists and a deliberate splitting of the transference is needed to provide reality support for such individuals and to maximize their chances in psychotherapy (6).

done as soon as the resistance is suspected, and usually only one patient at a time is involved. The group-as-a-whole model does not allow for this task to be performed, and it thus increases the likelihood of acting-out. More generally, resistances of individual group members must be overlooked when the group-as-a-whole model is strictly adhered to, and opportunities to stop resistive acting-out are decreased. Whenever the pressure for change produces discomfort and anxiety, a ready escape valve is available which dooms the effectiveness of most psychotherapeutic efforts.

Since no two individuals are the same, it is very unlikely that they would ever react in identical ways to the same stimulus, unless it were extreme. When eight individuals in a room all react similarly, the probability is high that such reactions result from ignoring their individual differences and from repeatedly focusing on what is common to them all. Group resistances do not just occur in a vacuum; they are usually the product of the therapist's interventions. The group-as-a-whole approach promotes group cohesion, and its underlying assumption is that one's sense of security is derived not from intrapsychic resources but from interdependence upon others, outside and other than one's self. Individual differences are commonly submerged in the group's identity. Patients follow such clues and also submerge their individual resistances in the group's resistance, thus minimizing their exposure and vulnerability. Opportunities for specific working-through of individual resistances are thus lost, and a tug-of-war often develops between therapist, on the one side, and the whole group, on the other. Such situations represent at best a waste of time and effort, and they retard the psychotherapeutic process. In extreme cases the continuation of therapy may be totally endangered.

When group therapy as such is criticized by those not directly engaged in its practice, they commonly have the group-as-a-whole in mind, as if it were synonymous with group therapy in general. The arguments used in such critical remarks are basically the same as those made in this section, and while not applicable to other group therapy models, their frequent and repeated use is probably some indication of their validity.

5) What holds individual patients in the group-as-a-whole and what brings them back session after session? Lack of choice or the existence of a positive transference is simply not adequate as a full explanation. What really helps patients tolerate repeated deprivations by the therapist is the support they receive from their peers in the group, all of whom face together the withholding authority, the "common enemy." The setting and the circumstances which promote group cohesion also create a de-facto split in the transference between a "giving" group and a basically "non-giving" therapist. Individual identities within the peer group have relatively few chances to find expression, not only because the therapeutic interventions are directed at the whole group, but also because of the patients' subjective need to hold on to the source of their mutual support.

The successful end point of reconstructive psychotherapy is more commonly

defined in terms of completion of the process of separation-individuation, which means that one can basically exist as an anxiety-free, whole and self-contained person. In the push to individuate, patients must overcome the universal wish for a symbiotic tie with Mother or her many surrogates. The ultimate usefulness of various psychotherapeutic interventions and models must be judged, therefore, by their effectiveness in helping or retarding the push towards autonomy and individuated existence. The group-as-a-whole model obviously scores low on that scale, for all the reasons enumerated.

When the group is repeatedly addressed as a whole and the individual within it is repeatedly overlooked as a separate being, individuation becomes more difficult, regardless of theoretical claims. Individuals often tend to congregate in groups to minimize their anxiety, and all psychotherapeutic efforts in a group setting must consistently attempt to reverse this tendency, which is commonly used as a resistance. Even in a group, the individual patient must realize that he can exist safely as a separate person, no longer attached to Mother, physically and emotionally. True intimacy and temporary dependence on another person are not possible until a person knows that he really can provide for himself, thus eliminating the terrible fear of abandonment. The basic emphasis in the group-as-a-whole model is, therefore, in the wrong direction, and, to the extent that desirable results are achieved, the therapist usually deserves the credit, not the holistic model.

CONCLUSION

The group-as-a-whole model is probably rarely, if ever, strictly adhered to in actual clinical practice. It is almost always used in a modified form, and even its ardent proponents often describe various deviations from the pure model because of shortcomings that are inherent in its very nature. The time has probably arrived, therefore, to discard it as a separate entity. When group-as-a-whole techniques are temporarily used to shake group members out of their delusional expectations for help from others, they ought to be described as techniques and their short-lived usefulness should be emphasized.

Even Foulkes (9) displays some ambivalence and conflict in regard to these issues. He states that "the ego processes, ... are in my view shared by the total group. They are analyzable in the context of the total group interaction *by the group themselves* (sic!) as well as by the conductor" (p. 112). Unless this represents a typographical error, he is either speaking of the group "itself" or of individuals "themselves," but, just as the language in the present form makes no sense, so neither does the model. Although Foulkes conceded the need to "address individuals or the group" (p. 110), he also believed that one patient mysteriously "always (sic!) reflect(ed) the mood of the group and its unconscious current in her person" (p. 139). The holistic model in pure form simply ignores

the obvious clinical reality that any group is composed of disparate and distinct individuals, each having his or her own needs and wishes which change from moment to moment. Group "moods" occur only when patients distort themselves to fit their therapist's expectations.

Experienced and intuitive therapists who take their task seriously and who attend to it with devotion and compassion achieve partial results with any model. Such achievements basically reflect the impact of their personalities and of the quality of their relationships. Patients need and deserve more than partial results, however, and choice of the correct psychotherapy model increases their chances of obtaining positive outcomes. Models that inhibit and sometimes even interfere with therapeutic tasks not only discourage experienced therapists, but also needlessly complicate the teaching of novices. The group-as-a-whole model can profitably be used to demonstrate group processes and especially group formation, but it ought to be discarded as a regular therapeutic tool.

REFERENCES

1. Bales, R.F.: The equilibrium problem in small groups. *In*: Hare, Paul, et al. (Eds.): Small Groups; Studies and Social Interaction, New York 1967.
2. Bar-Levav, R.: Behavior change—insignificant and significant, apparent and real. *In*: Burton, A. (Ed.), What Makes Behavior Change Possible. New York, Brunner/Mazel, 1976.
3. Bar-Levav, R.: Group psychotherapy—a technique in search of a theory. *In*: Wolberg, L.R., & Aronson, M.L. (Eds.), Group Therapy, 1976. New York, Stratton Intercontinental Medical Books, pg. 134, 1976.
4. Bar-Levav, R.: The treatment of preverbal hunger and rage in a group. Int. J. of Grp. Psychotherapy, 27/4, 457-469, New York, Int. Universities Press, 1977.
5. Bar-Levav, R.: The psychotherapy group—one essential ingredient for character change. Paper presented at The Am. Group Psychotherapy Assoc. Annual Conference, New Orleans, La., Feb., 1978. Unpublished.
6. Bar-Levav, R.: The transference-split in the treatment of borderline patients: 60-Min., 3/4" Cassette Videotape, produced by The Bar-Levav Educational Association, Detroit, Michigan, 1977.
7. Bion, W.R.: Experiences in Groups and Other Papers. New York, Basic Books, 1959.
8. Ezriel, I.T.: Notes on psychoanalytic group therapy: Interpretation and research. Psychiatry, 15: 119-126, 1952.
9. Foulkes, S. H.: Group-Analytic Psychotherapy, Method and Principles. New York: Gordon and Breach, Science Publishers, 1975.
10. Freud, S.: Group Psychology and the analysis of the ego. The Standard Edition of the Complete Psychological Works of Sigmund Freud, 18. London, The Hogarth Press, 1955.
11. Grotjahn, M.: In Memorium. Int. J. Grp. Psychotherapy, No.1, Vol. 27, January, 1977, pg. 127.
12. Horwitz, L: Group-centered approach to therapy. Intl. J. Grp. Psychotherapy, 27: 423-439, 1977.
13. Janov, A.: The Primal Scream. New York, Putman, 1970.
14. Lowen, A.: The Language of the Body. New York, Macmillan, 1958.
15. Perls, F.: Ego, Hunger and Aggression. New York, Random House, 1969.
16. Redl, F.: Group Emotion and Leadership. In: Hare, Borgatta and Bales (Eds.), Small Groups: Studies in Social Interaction. New York, Knopf, 1967.
17. Rolf, I.P.: Rolfing: The Integration of Human Structures. California: Dennis-Landman, 1977.
18. Rosen, J.: Direct Psychoanalysis, Vols. 1 & 2. New York, Grune and Stratton, 1953.

19. Slavson, S.R.: A textbook in Analytic Group Psychotherapy. New York, Int. Universities Press, 1964.
20. Spotnitz, H.: Treatment of the Narcissistic Neuroses. New York, The Manhattan Center for Advanced Psychoanalytic Studies, 1976.
21. Wolf, A. and Schwartz, E.K.: Psychoanalysis in Groups. New York, Grune and Stratton, 1962.