Group

Supervision

Notebook

Dale C. Godby, PhD, LLC

American Board of Professional Psychology, ABPP
Certified Group Therapist, CGP

Some Thoughts Before Beginning

"Of Camille Saint-Saëns, one of the nineteenth century's greatest prodigies, who lived in the constant sunlight of adulation, Hector Berlioz said, 'He knows everything, but he lacks **inexperience.** '"

Andrew Soloman
"Evgeny Kissin." *New Yorker,* Aug. 26- Sept. 2, 1996.

Your job during supervision, in part will be to take full advantage of your **inexperience,** you won't be able to claim it for long.

Murray Cox tells a story of a nearly mortal narcissistic wound he received during his early days at Cambridge. His teachers after looking at some of his preliminary papers told him, "It appears you know so remarkably little that there is every chance we can teach you something."

Scott Rutan tells his supervisees that he measures their success by how freely they can make mistakes during their time of supervision. So communicate your mistakes freely and work to avoid what has been referred to as the "botchful eye," "sage fright," and carper-fumble syndrome."

In every work of genius we recognize our own rejected thoughts; they come back to us with a certain alienated majesty....

Ralph Waldo Emerson
Essay on Self Reliance

Before we are done you will learn to accept your "rejected thoughts" and feelings and learn to test them against how well they help your patients move out of their suffering toward greater freedom.

GROUP SUPERVISION NOTEBOOK

INTRODUCTION AND DIDACTIC

A good education in group psychotherapy requires **EXPERIENTIAL, DIDACTIC, OBSERVATIONAL** and **SUPERVISORY** components. The supervisory component will be the primary focus here. Supervision ideally follows the other three components.

The best web site for group psychotherapy information is run by Haim Weinberg, PhD: www.group-psychotherapy.com. If you can find a site, journal, book, or organization related to group that he has not listed, let him know and he will add it.

If you would like to join a group organization I would start with the American Group Psychotherapy Association, AGPA, www.AGPA.org. Print off the application at the end of this packet and they will give you a free trial membership. They have an annual meeting in the third week of February. This year, 2011, they will meet in New York City. The first three days of the meeting are dedicated to experiential learning and the last three days to workshops. I have attended a variety of professional meetings and this is the one I consistently return to, largely because of the experiential learning that is at the center of the experience.

You will find more than a lifetime of reading at Haim's site, but I can't resist listing a few of my favorite group books:

Reading

Gans, J.S. (2010). *Difficult topics in group psychotherapy: My journey from shame to courage.* London: Karnac Books Ltd.

Nitsun, M. (2006). *The group as an object of desire: Exploring sexuality in group therapy.* London and New York: Routledge.

Nitsun, M. (1996). *The anti-group: Destructive forces in the group and their creative potential.* London and New York: Routledge.

Ormont, L.R. (1992). *The group therapy experience: From theory to practice.* New York: St. Martin's Press.

Rutan, J.S., Stone, W.N. and Shay, J. (2007). *Psychodynamic group psychotherapy.* 4th Edition. New York: Guilford Press.

Yalom, I.D. and Leszcz, M. (2005). *The theory and practice of group psychotherapy.* 5th Edition. New York; Basic Books.

Collections

Alonso, A. and Swiller, H.I. (Eds.) (1993). *Group therapy and clinical practice.* Washington D.C.: American Psychiatric Press.

Kaplan, H.I. and Sadock, B.J. (Eds.) (1993). *Comprehensive group psychotherapy.* 3rd Edition. Baltimore: Williams & Wilkins.

EXPERIENTIAL

Experiential learning is important in many group therapy programs. For example, the Institute of Group Analysis in London http://www.groupanalysis.org has a four year training program that requires participation in an experience group for 1½ hours over 30 weeks in their introductory group course. This is followed by a group analysis that occurs twice a week for 3 or more years. Experiential learning or what is frequently called a training group or T-group should be differentiated from group psychotherapy or group analysis. T-group is not therapy in the sense that you are often required to participate in T-group as an exercise to study yourself and group dynamics. Whereas therapy is chosen for a particular issue you are facing in your interpersonal relationships that you would like to change.

The American Group Psychotherapy Association (AGPA) (www.agpa.org) holds a meeting each year, which dedicates 2 to 3 complete days to experiential learning similar to T-group. Below is an article by Len Horwitz, PhD that serves as an introduction to the type of learning that is available to you in the T-group and in the experiential portion of the AGPA meeting, which is referred to as the Institute.

Exciting Opportunities Ahead

by *Leonard Horwitz, Ph.D.*
Taken from International Journal of Group Psychotherapy, Vol. 49(1), 1999

I have participated in numerous experiential training groups over the years both as a leader and as a member. I can assure you that the most vivid memories I have come from those that I experienced as a member. They have been among

the most important learning experiences that I have had during my career. Let me try to explain why training groups are so valuable for a group therapist.

***First*, you will have the opportunity to understand in depth through direct experience the kind of inner struggles patients undergo as they attempt to form relationships and use a group for personal growth.** I still remember vividly my fears of diving into the uncertain waters of these groups, and I knew that I either screwed my courage to the sticking post and entered into the fray or left the group feeling like I did not have the guts to risk exposing an aspect of my personal life that perhaps portrayed me in a less than favorable light.

When I thought about it, there were plenty of issues in my personal life to discuss--problems with colleagues, bosses, parents, children, spouse--but did I want to share any of them with a group of strangers? How would they react? Would I be criticized, humiliated or the worst of all--ignored? Would everyone at American Group Psychotherapy Association (AGPA) hear about it the next day? These are the very same anxieties our patients have when they enter and try to participate in a group. And there is no better way to learn about such struggles than to undergo them yourself, to feel them inside and firsthand--not from a book. It makes you more sensitive to your patients and a great deal more tolerant of other people's resistances. Much as we all desire help from others, there are inevitable anxieties, inhibitions, and shameful feelings that make us want to withhold and withdraw.

Because we are all professional helpers, it is not uncommon for us to adopt the role of therapist's assistant, hiding behind one's persona as a clinician to deal only with the problem of others. Groups of professionals sometimes appear like 12 therapists in search of a patient.

Another favorite escape hatch, used by patients as well as by us therapists, is to retreat into the role of silent observer. After all, one is there to learn how groups function, how members and patients interact, and what better way than to be a fly on the wall? Let me assure you that such a role will not only make you a problem member, but you will be cheating yourself of a potentially rich experience of being as full a participant as possible.

So far I have described only the advantage of learning better how our patients feel. But there is also the possibility, nay the probability, that ***you will learn something important about yourself***. If you tend to monopolize or conversely, if you are too silent, you are likely to hear about it from your fellow members. If you are too self-absorbed and don't attend sufficiently to others, you will probably be told about it. If you don't reflect about what others tell you, let it bounce off your back or ignore it, the group will tell you. Most often these reminders will be relatively gentle and given in a constructive manner. In any case this personal feedback about how you come across in a group, how you behave as a group member, can be extremely helpful in expanding your self-awareness.

Another way of learning more about oneself is also by silent self-observation. I began to observe in more than one group that I was constantly evaluating leaders' interventions, giving them grades for their performance. More often than not they fell short of my expectations, and I often persuaded myself silently that I could do a better job. One leader didn't take well to negative transference and discouraged its expression, another talked in strange metaphoric language, whereas still another made weak eye contact with members. Although some of these criticisms may have been warranted, the more important lesson I began to learn was about my own competitiveness with authority figures.

This brings me to another rich source of learning, that is, ***the opportunity to observe an experienced group therapist in action.*** If you are not intent on criticizing the group leader, as I was, you will be able to learn about a skilled clinician's approach to a group, how he or she thinks, what gets observed, interpreted, or confronted. When is the therapist silent and when interpretive? When is the intervention addressed to the group and when to an individual? What interventions seemed to work and move the process forward and which were ineffective? In individual psychotherapy training, we rarely see our supervisors and mentors in action. Groups are unique in providing clinicians an opportunity to watch, evaluate, and learn from a mature therapist.

Still another learning experience is the opportunity to become knowledgeable about group dynamics. I have learned more about these matters as a participant than as a therapist, probably because the role of observer without the responsibility of managing the group permits more relaxed opportunities to study what is transpiring. I was a member of an unstructured group some years ago, where I observed a striking combination of group dynamics that was very instructive and memorable. This was a group in which it was difficult for members to express hostility or criticism, mainly to the leader. Some tentative jibes at the leader resulted in certain nonverbal reactions, like tightening of his facial muscles, that convinced the group that this was a leader who was not exactly welcoming of such behavior. As a result the group found a spokesperson, Dan, whose disposition to freely express negative feelings made him a likely candidate to fill that role for them. They subtly encouraged Dan to speak up and he was more than happy to vent his spleen at the leader. Does this sound like projective identification? Indeed it does. It is also the basis for role suction.

But when Dan began to express his criticisms of the leader, the group gave him little support and, in fact, began to ostracize him for his unwlecome ideas, which in turn made his devaluations of the leader even more extravagant. This scapegoating made it necessary eventually for him to leave the group. I remember his departure quite vividly because he left with some fanfare in which he went around the room describing the Achilles' heel of each member and then nominated me to carry on the good fight, an invitation that I wisely declined. The

whole episode was a memorable experience, which I have put to good use in my understanding and teaching about group phenomena.

I would like to mention one last potential benefit from experiential groups. It has the possibility of throwing light on problems of authority, leadership, and followership in organizations. Some years ago the Menninger Clinic was undergoing a radical change in leadership, and the torch was being passed from the founder, Dr. Karl Menninger, to the next generation, led by Dr. Roy Menninger. The staff needed to give up its dependency on a strong charismatic father figure and begin taking more responsibility for decision making. At that time the organization turned to the A.K. Rice Institute's group-relations conferences, an experiential method for studying organizations, and most of the staff attended at least 1 week-long conference. We did a follow-up study some 10 years afterward and most of the participants still spoke enthusiastically about the important learning they had gained from the experience. There was little doubt that the organization had become better able to negotiate the needed shift from a dependency culture to one in which greater autonomy was called for.

I have often tried to understand the various factors that have led to making the AGPA as successful an organization as it has become. Most of us who have been associated with AGPA have a sense of closeness and bonding with the organization and with our peers that makes membership highly valued. Over and above the professional and scientific benefits, we form close friendships that enrich us. I believe that the Institute experience contributes in no small measure to the personal relationships that develop. Friendships made in these groups often continue and endure.

What you are about to enter is a 2-day intensive personal experience in which you have the opportunity to learn about yourself, to learn about group leadership, and to learn about group dynamics--all in a way that you can't possibly learn from reading. You may even get a new perspective about a problem in your personal life. Each of you will make unique observations and will carry away different facets of the experience, depending on where you are in your own development as a clinician and as a person. If you are especially motivated to learn more about yourself, you will probably come away with new insights. If you are interested in focusing on techniques of leadership, those learnings will be paramount.

This will be a challenging and exciting adventure in personal growth. I am certain that the experience will stay with you forever. My recommendation: ***Seize the opportunity.***

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Leonard Horwitz is Training and Supervising Psychoanalyst, Topeka Institute for Psychoanalysis, The Menninger Clinic, Topeka, Kansas.

3

OBSERVATION

Observing expert an clinician running groups is an important part of learning group. By the time you get supervision you hopefully have seen the tapes of Yalom and others running group and have had the opportunity to observe well run groups at your clinical placements.

Each member of your group at UTSWMC should know that they will be observed by a senior faculty consultant and students who are learning group. This observation will be conducted along the lines of Yalom (1983). We will be primarily observing the group leader. The observation will focus on the information found in the tables reproduced from Rutan and Stone and Kennard, Roberts, and Winter. Groups can be usefully understood as comprising:

1) Structure
2) Process
3) Content

Table 2 – Deciding to intervene

What is the state that I am observing?

⇩

What processes are contributing to it?

⇩

Do I judge it to be constructive, destructive or neutral?

⇩

Would it be advantageous to change this state?

⇩

Is it possible to change it?

⇩

What intervention(s) might influence the constituent processes and state?

⇩

Is the necessary intervention within my repertoire?

⇩

Is the time ripe for an intervention?

Table 3 – A classification of conductor interventions

1. Maintenance (structure)
2. Open facilitation (process)
3. Guided facilitation (process)
4. Interpretation (content)
5. No immediate response
6. Action
7. Self-disclosure
8. Modelling

Table 4 – Definitions of Intervention type

1. **Maintenance** interventions are those aimed at clarifying or re-affirming a relevant boundary. This may be a boundary of place, time, membership, task or permitted behaviour and may concern the boundaries of the group as a whole or of a particular member including the conductor.

2. **Open facilitation** is an intervention aimed at promoting the forward movement of the group process, but not based on any particular interpretative hypothesis on the part of the conductor and not referring to unconscious levels of awareness.

3. **Guided facilitation** includes all facilitating remarks that are not simply open-ended, but which indicate that the conductor has a hypothesis in mind, which is guiding his questioning, prompting and observations.

4. **Interpretation** involves verbal intervention by the conductor, which makes manifest feelings, or meanings, which are latent in what the group as a whole, or its individual members are saying.

5. **No immediate response** is a coding which acknowledges that during the course of an ongoing group, a significant part of the bahaviour of the conductor will involve silent observation of his group. In response to the group situations, there will be occasions when the conductor does or says nothing in response to the situation, reserving the right to intervene later, depending on the further development of the situation.

6. **Action** refers to any kind of physical activity that the group conductor might engage in inside the group, which involves leaving his/her chair or touching another group member.

7. **Self-disclosure** is any declaration by the therapist about the content of his own inner world, or his outer world, which does not fit in any other category of intervention.

8. **Modelling** is any activity on the part of the conductor that contains an implicit intention that it should be identified with and become part of the repertoire of behavior of the group or its members from whom it was previously absent. This would include coping adequately with distressing events, or uncomfortable social situations and also the modelling of an analytic inquiring and concerned attitude.

Kennard, Roberts, and Winter, (1993), pp 6-8.

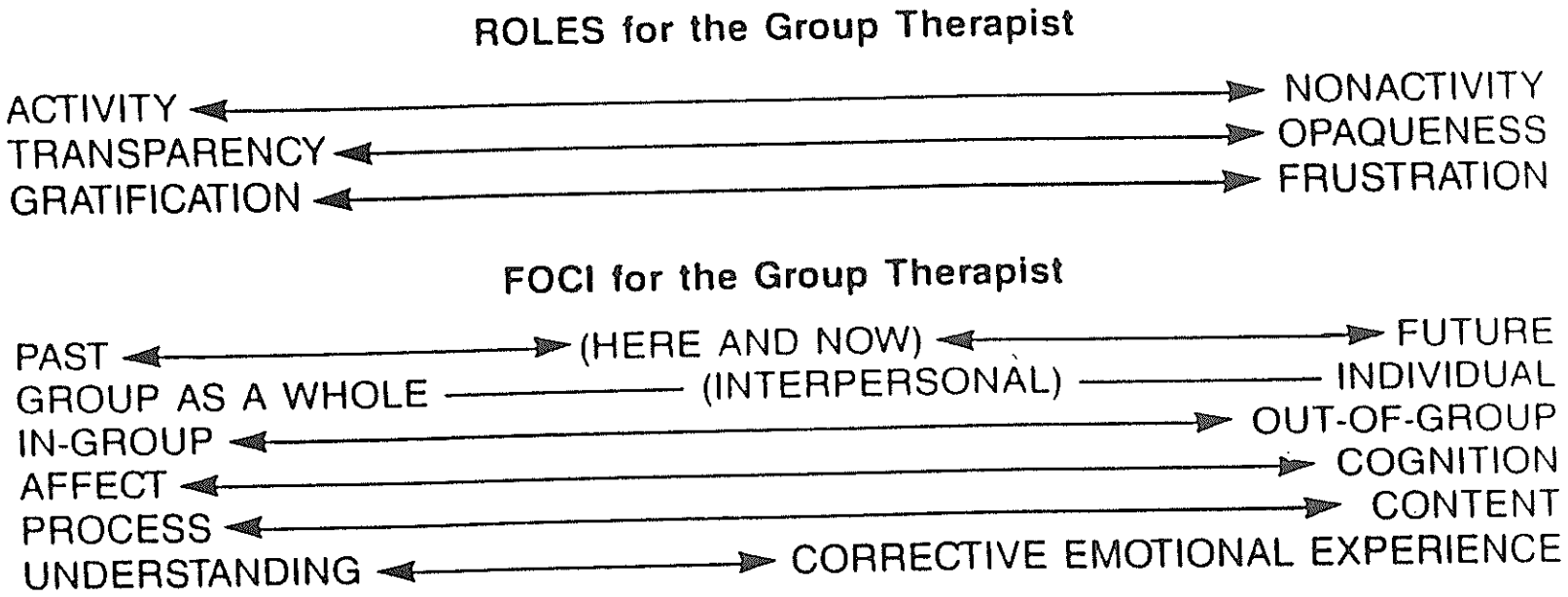


FIGURE 8.1. Leadership dimensions of the group therapist.

Rutan and Stone, (1993), p. 128

Books by the Same Author

Theory and Practice of Group Psychotherapy

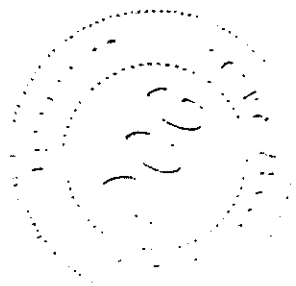
Every Day Gets a Little Closer: A Twice-Told Therapy
(with Ginny Elkin)

Encounter Groups: First Facts
(with Morton A. Lieberman and Matthew B. Miles)

Existential Psychotherapy

INPATIENT GROUP PSYCHOTHERAPY

Irvin D. Yalom



Basic Books, Inc., Publishers *New York*

1983

In their discussion the leaders review the course of the meeting with particular focus upon their own leadership. They may wonder what they missed, what else they might have done in the group, whether they left out certain members, whether there would have been better ways to handle a particular situation in the group.

The observers are encouraged to participate actively in this discussion. The only instructions are that they attempt to make all their comments constructive; that if they are going to be critical, they confine criticism to the leaders; and that they attempt, if possible, to say something about each member of the group. Observers are also advised to avoid describing a group as "boring"—a comment that is never constructive and invariably evokes defensiveness and resentment on the part of the patients. (As a general rule, observers of a psychotherapeutic process who feel bored do so out of inexperience or a lack of knowledge about the dynamics of the patients. The more one knows about therapy, the more interesting does each therapy session become.)

The therapists make an attempt to discuss, even briefly, their view of each patient's experience—the type of agenda, the degree of activity or involvement, the work done on the agenda —and their estimation of each patient's degree of satisfaction. They discuss the entire course of the meeting, the general group climate, degree of engagement, irritation, or dissatisfaction; review the choices that they made in the meeting; and raise the question of others they might have exercised or of important issues they may have overlooked.

In the final ten minutes the meeting is once again thrown open to the patients. They generally spend most of this time responding to the observer(s)'s comments, exploring issues suggested in the therapists' discussion, processing the meeting themselves or, occasionally, working on unfinished business of the session.

Yalom, 1983

Format of the Final Phase: Evolution and Justification

As the "wrap-up" format I recommend is not traditional, I consider it necessary to describe its development and justification.

Evolution

Since I lead groups in a university hospital, I often have students (generally two to four) observing my groups, generally through a two-way mirror. For a period of many months, I used a traditional format for observation: the students observed the group, and afterward we (co-therapists and observers) met privately to analyze the meeting. Patients never respond favorably to such an observational format. Although they appreciate the necessity for on-site training for young clinicians, patients nevertheless feel "used" and intruded upon. The patients on my ward expressed much disgruntlement: they did not like to be "guinea pigs"; they raised the question of whether they were the "main act" or whether the group was primarily for the students (as one patient put it, "Which side of the mirror are the therapists on?"). Other patients commented that observers robbed the group of a sense of intimacy or dignity.

Other patients feared the observers would not respect the confidentiality of the therapy meeting. Some patients, especially those with paranoid ideation, were so threatened by the observational procedure that they removed themselves, either physically or psychologically, from the group. All attempts to reassure the group members about confidentiality, to introduce them to the observers, to remind the members that the patient is the primary concern in good teaching, failed to dispel the patients' discontent at being observed.

Later, in an effort to reduce the adverse affects of observation and to make the process useful to patients, I employed another

format: at the end of the group, patients and observers switched places, the former entering the observation room and observing the student-observers and the therapists as they discussed the meeting. Finally, in an effort to save time, the observers simply entered the group room after the meeting and, forming a small circle with the therapists, spent ten to fifteen minutes in discussion, to which the patients silently listened.

Patients were intensively interested in the observer-therapist discussion. Over and over they commented on the many feelings and thoughts it evoked, and regretted having to end the meeting without the opportunity to air them. Furthermore, many patients wished to interact with the observers, either to obtain clarification of a comment one had made or to respond to a question one had posed.

The final step evolved naturally: ten minutes were added to the meeting to provide patients with an opportunity to express their reactions to the observer-therapist discussion, to pose questions, and to pursue work that had been stimulated by observer or therapist comments.

The response of the overwhelming majority of patients to this format has been unequivocally positive. With one stroke the observational process was transformed from a negative experience into a valuable component of the group therapeutic procedure. The input of the observers was so valuable that patients were invariably disappointed if none were present on a particular day. In fact, one patient felt so strongly about the positive value of hearing the observers discuss the group that each day, before deciding to attend a session, she checked the observation room to make sure there were observers present.

The Stanford group therapy research project specifically inquired into patients' reactions to this format, and there was strong consensus that the final twenty minutes was an integral, vital part of the therapy group session. When patients were asked what percentage of the value of the group stemmed from the last twenty minutes, they placed on it a value that far

exceeded the actual time involved. Some patients, in fact, ascribed to the final twenty minutes a value of as high as 75 percent of the total group value.

Rationale

Though this procedure may seem unconventional and threatening to many therapists, it is based on fundamental group therapy principles. Earlier I emphasized that, to be therapeutic, the here-and-now approach must include two stages: the *experiencing* component, which is followed by *reflection upon* (or processing of) that experience. Interpersonally based psychotherapy consists of an alternating sequence: first, affect is evoked, and then that affect must be analyzed and integrated. The final phase represents the second, the self-reflective, phase of the here-and-now.

This phase does not constitute the entire processing or understanding of the experiencing phase of the here-and-now. I have provided many examples of the therapist's explaining or clarifying some important experience in the group. The therapist might, for example, "stop the action" and suggest to the group, "Let's try to make some sense of what has just been happening"; or, in a variety of ways, offer clarifications or interpretations based on here-and-now events.

But the final phase is a highly concentrated period of process commentary in which the therapists and any observers review all the key events of a meeting in an attempt to provide the patients with a cognitive framework for the events of the session.

Antecedents of the "wrap-up" Format

Though the self-disclosure required of the therapist in this format may seem considerable, the procedure of patients observing group leaders and observers is not without precedent. In fact, the origins of the sensitivity-training group date back to such a procedure.[3] In 1946, in a summer institute for commu-

nity leaders, a group of observers met each night to discuss the process of the discussion group they had observed during the day. When the members of the group learned about these nightly sessions, they asked to observe the discussion. The laboratory leader, with some trepidation, agreed; and for several evenings, the group members sat in an outer concentric circle listening to the observers discuss them. This proved to be a compelling experience and generated enormous interest and interaction. The leaders of the laboratory realized that they had stumbled onto a powerful tool of education—that is, experiential learning; and from this insight developed the sensitivity group with built-in mechanisms for feedback both from members and from leaders.

A regular component of early sensitivity-training groups (or T-groups) in summer laboratories was the "fishbowling" exercise. In this format one group sat in a circle around another group; and periodically chairs were switched so that the outer group became the inner and discussed the process of the inner group they had just observed.

There are two reports in the literature of a "fishbowling" format being used in inpatient groups.[4] In these groups the patients met in an inner circle without a leader, while the staff observed from the outer circle. In the final fifteen minutes, the groups exchanged places, and the patients heard the staff discuss their leaderless session.

There is precedent for this format in outpatient practice. I have, for many years, invited members of my long-term outpatient groups to observe my student-observers discuss them after a session; and Eric Berne has reported a similar procedure.[5] Over a period of fifteen years I have used a related technique —a shared, written group summary.[6] At the end of outpatient group sessions I write a detailed group summary (an editorialized narrative summary, including detailed process analysis and considerable disclosure of my strategic therapeutic plan) and mail it to the members before the next week's session.

The Higher-Level Inpatient Therapy Group

"Multiple therapy" is yet another example of a procedure in which patients observe their therapists discuss the treatment process.[7] In this procedure, used for the teaching of psychotherapy, several therapists (usually one or two teachers and four to five trainees) meet together with one patient for a series of sessions. During these meetings the therapists interact individually or jointly with the patient but often may engage in a discussion among themselves analyzing some particular aspect of the interaction of the entire group. The therapists may disagree with one another or question one another about the reasons for a particular statement or question. Obviously this format has no economic future, but it has proven an excellent teaching vehicle and is invariably regarded as beneficial by patients.

Each of these formats—the observed inpatient group "wrap-up," the observed outpatient observer discussion, the group summary technique, multiple therapy, T-group "fishbowling" —entail considerable therapist (or observer) disclosure—especially disclosure about the "innards" of the therapeutic process. Each of these formats emphasizes analysis of process, and each provides patients with some cognitive framework by which one is able to make sense of the here-and-now interaction and transfer what one has learned in therapy into other situations in life.

None of the many possible objections to this procedure (for example, that patients who know too much about the therapeutic strategic procedure, or are aware of the therapist's uncertainty or lack of conviction about certain areas, will cease to have faith in therapists) have materialized. In each of these formats, patients are intrigued by the discussion, feel validated that the therapist treats them with respect by involving them in the discussion of their own therapy, have more respect rather than less for the therapist as a result of his or her sharing of uncertainty, and invariably profit from the cognitive framework with which they have been provided. One of the major

results of such a procedure is that therapy becomes demystified. Patients begin to understand that there is nothing mysterious or magical about the therapist or the therapeutic procedure. As a result, they are less likely to be dependent upon the therapist or to be infantalized by the therapeutic procedure.

Other Advantages of the "Wrap-up" Format

Patients have a wide array of reactions while observing the final discussion, but one strong reaction is shared by all patients: they find it a compelling experience to hear themselves being discussed by others. Whatever the reason (I have always regarded it as analagous to the child listening outside his parents' bedroom door as they talk about him), the interest in this phase of the meeting is heightened and consequently becomes heightened for *all* phases. The greater the interest and engagement of the members, the more important does the group become to each. The greater grasp that members have upon the cognitive framework of the group therapy procedure, the more relevant and valued does the work of the group become. This enhancement of cohesiveness facilitates a host of other therapeutic activities: patients trust one another more, they self-disclose more, they feel closer to one another, they develop more trust in the therapist and the therapeutic procedure.

The final phase is an excellent opportunity for therapists to do some invaluable modeling. For example, co-therapists may discuss some of the dilemmas and concerns that they have experienced during the meeting. They may express their puzzlement about what they might have done differently to help a negativistic patient; they may ask the observers for feedback about their (the therapists') behavior. Were they, for example, too intrusive? Or, did they put too much pressure on a particular patient?

It is advisable for therapists to share some of the dilemmas they have faced in a meeting. For example, you might state in

the final discussion that you very much wanted to help a patient who is in a particularly bad spot that day, yet are also aware that this is the first meeting she has chosen to attend although she's been on the ward for several days. You have assumed that she is anxious about groups, and thus are caught between wanting to help her and yet feeling uneasy about possibly threatening her in some way by calling upon her or encouraging her participation.

A therapist can also model modes of examining relationships by exploring his or her relationship with the co-leader. You may, for example, raise the question to the observers of whether you were too active, or shut out the co-therapist, or might have made a greater effort to follow leads opened up by the co-therapist.

For example, in one session a patient stated that she experienced one of the co-therapists as very cold and formal, and that she had a hard time feeling that he cared for any of the patients. That therapist responded that he did have a sense of wanting to be in control but at the same time regretted that it got in the way of his work. Some of the other patients agreed that he had a very formal style which they often experienced as aloofness. During the final phase the observers continued the discussion and agreed with the patients that this therapist created more distance between himself and the patients than did the other therapist in the group. The observers pointed out that whenever he was confronted by patients, he immediately began using polysyllabic and professional terms as a way, perhaps, of keeping the patients in their place. The therapist accepted this feedback and said that it was accurate and that he was feeling uncomfortable in the group. He pointed out how, for one thing, he did not have a great deal of group experience and felt uncomfortable working with a co-therapist who was extremely experienced in groups. The patients felt validated by his taking their comments seriously; they gained respect for the

therapeutic procedure by witnessing the therapist open himself up for feedback; and they ended the session with more, rather than less, confidence in him as a therapist.

The final phase helps the reality testing of many patients. If members are confused and unable to make sense of some of the events of the session, it is enormously confirming for them to hear the observers make the same observations. Patients who feel that a group session is testy, adversarial, or ineffective, are "grounded" by hearing the therapists and observers make the same observation.

The input of the observers augments the potency of the group. The addition of several pairs of eyes and ears generates information. The observers note many things that the therapists have missed: nonverbal communication, patients who seemed disappointed, unfilled agendas, subtle transactions that took place off "center stage."

The observer-therapist discussion also helps to bring in the silent members of the meeting. The observers attempt to make some observation about each member and to guess at the experience of each of the silent members. This process opens the door for these patients to participate, even briefly, during the final ten minutes.

The observers' feedback is invariably given considerable weight. If, during a session, a member is told that he or she is impersonal or distant, that observation is made much more potent when observers make similar comments. Conversely, any negative comments by observers are particularly painful and often have enduring negative effects. Thus, it is important that the observers not be critical in a condescending way. Such statements as "the patient is playing games" or is "manipulative" invariably increase defensiveness and close down, rather than open, a patient to learning.

Observers, no less than therapists, must phrase their comments in such a supportive manner as: "The patient wants but fears closeness"; "There is something about therapy that frightens the patient"; "The patient seems to crave help but isn't yet clear about what kind of help would be best."

Occasionally observer criticism works paradoxically. I have witnessed many meetings in which the observers criticized the group for having not worked productively, and the group responded by becoming more cohesive than previously in the session and defending the work its members had done. (An attack by some outside group almost invariably strengthens the cohesion of any group; that's precisely why the ruler of a tottering political regime may often seek to strengthen his position by entering into a war with another country.)

Another important aspect of the final phase is that patients become acutely aware of the members who receive the bulk of the observers' attention. Patients want to be noticed and to be discussed, and they may feel slighted, neglected, or envious of those patients who receive most of the observers' attention. Therapists may then pursue the theme of each member's responsibility for what he or she receives from the observers. The equation is self-evident: if one is inactive during a meeting, it invariably follows that one will get relatively little attention during the "wrap-up."

A clinical vignette illustrates how profound wishes to be noticed and nurtured may be evoked by this final group phase. Paula, a thirty-eight-year-old patient, had effectively stymied therapy by her posture of extreme skepticism. She stated that everything in life, and especially everything that happened in the therapy group, was phony. She insisted on the phoniness of the feelings that the people demonstrated in the group. She knew that her feelings were phony because she created them capriciously; they were immaterial and not to be believed or taken seriously.

The therapist tried to reach Paula by speaking to her healthier side; he commented that, despite these pessimistic feelings, she still came to the group every day; obviously there was a part of her that wanted to get better. Why then, he wondered, did she

persist in trying to defeat therapy? Why come faithfully to therapy every day and yet refuse to work? Paula then stated that she had worked in the group on a couple of occasions, but what was the point of it? Even when she did, her work was never acknowledged by the observers or the therapists in their final discussion.

The therapist noted that Paula stated this with a great deal of feeling and tears in her eyes. Here, at last, was a genuine feeling—one that Paula couldn't discard as phony or capricious! The therapist zeroed in on this perception, observing that Paula was deeply moved and asking her to share more of her feelings about receiving little attention in the final discussion. What did she make of it? What were its implications for her? Paula replied that she feared it meant that the therapists and the observers had put her into the "big C" folder ("C" for "chronic").

This revelation opened the door for her to share many of her innermost thoughts: her wishes to be noticed, to be rescued; her longing for the therapist to cradle and care for her; her sense of having been betrayed by figures upon whom she'd depended all her life; and her wish for, but fear of, intimacy. Paula subsequently worked far more productively in the group. By chance I had the occasion to treat her two years later as an outpatient, and she gratuitously referred to this particular group therapy session as a critical turning point in her therapy.

The Patients' Response to the Therapist-Observer Discussion

The therapist-observer discussion invariably generates considerable data, which it is the task of the final ten minutes of the group to respond to and integrate. Generally it is a period of great animation; there is more potential work on the floor than can possibly be accomplished.

There are two major directions that this part of the meeting can take. First, the patients may respond to the observers. Patients have a wide and deep range of affective responses to the

therapist-observer discussion, and these ten minutes are often fully consumed by their sharing these reactions. Second, the final ten minutes is a time both for the patients themselves to process the meeting and to complete its unfinished business and for the therapist to touch base with any patients whom he or she feels may have been left out of the meeting.

Because the observers' comments frequently have a powerful impact upon the patients, it is particularly advisable for the therapist to attend to those patients who were most central in the "wrap-up" discussion. The therapist may simply ask what reactions they have to the observers' comments. Were the comments useful? Did members agree or disagree with the observers?

As the observers discuss the patients, it is fair game for the patients to turn the tables in the final ten minutes and discuss the observers and the therapists. Often patients comment upon the openness, or lack thereof, of the observers; patients may, for example, note that the climate of the discussion was more inhibited and uptight than the patient meeting. Sometimes they raise questions about the anxiety of the observers and inquire into the relationship between observers and therapists. I have heard patients engage the observers in a discussion of the latter's own performance anxiety, their uneasiness about being observed by the patients, or their concern about the therapist's evaluation of their comments.

The final discussion often serves as a projective test, and members may have a wide range of reactions to it. The patients' response to leader transparency is especially dramatic in this regard. Some patients so deeply distrust the staff that they suspect the therapists' behavior during their discussion. They accuse therapists of staging their discussion, of only pretending to ask the observers for advice, guidance, or feedback, of feigning uncertainty in order to lull the patients into blind trust.

It is obvious that some patients do not want to see the therapist as fallible, human, and potentially vulnerable. Whereas

most patients appreciate the honesty of the therapist, some patients are unsettled by discovering that therapists, too, have "feet of clay." However, these reactions, like others, can be a springboard into a fruitful discussion of attitudes toward authority, of dependency cravings, of the yearning to remain young and protected forever.

The final ten minutes is a time for patients to process and evaluate their own meeting. The more they are able to do this, the more likely are they to assume more responsibility for their therapy in the future. The first step of such responsibility assumption is for patients to develop an explicit definition of good therapeutic work. Without this clear yardstick, it is difficult for them to know which direction to take. The therapist is generally the only person in the group who has a clear definition of what constitutes a good therapeutic "work" meeting, and it is the therapist's task to help members arrive at a satisfactory definition. The therapist may label some meetings as particularly effective and comment, for example, that this is the type of meeting he or she hates to see come to an end. The therapist may guide patients toward a definition by asking them to evaluate what parts of the meeting felt best to them or how a particular meeting compared with a previous one.

The therapist may circle the group and ask each member to evaluate the session, inquiring: What kind of meeting was it for you today? Did you get what you wanted to out of it? Who got the most? Who the least? What were your major disappointments with this session? If this were not three P.M. [the end of the session] but only two-thirty, what might you do to avert this disappointment?

The therapist is well advised to make contact with the silent members before the end of the meeting and inquire into their experience during the session. It is often helpful to explore their silence by asking if there were times in the session when they wanted to speak. What stopped them? Were they hoping for the therapist to call on them? *If* they had said something, what

would it have been? (This last question is often miraculously facilitative.)

This line of questioning usually succeeds in helping silent members participate, at least in some limited way, in the group, and often a great deal of work can be done in a short period of time. For example, if—in response to this line of inquiry—a silent member, at the end of the meeting, offers some observation he or she almost made earlier about another member, the leader can immediately ask for a response from the other member or ask how it might have felt had the patient made that statement during the earlier part of the meeting.

Almost invariably the sequence of events is reinforcing for the patient. One may say that one was silent because everything one thought of saying had been said by someone else. The therapist can point out that, though that may be true, the fact remains that no one else really knew that this was the way that particular person felt. Therefore, one remains concealed from others—a state of affairs that patients will agree is not in their best interests. Not only can the therapist in this final phase engage the silent members in the meeting but, in so doing, can set the stage for their increased participation in the following session.

Conclusion

The current shape of this group therapy model evolved gradually over some four hundred meetings. During this period I made much use of trial and error and employed and then modified or dropped model after model. Throughout this time I have had considerable consultation from students and colleagues who observed almost all of my meetings and helped me analyze the meetings in debriefings afterward. I have had, in

addition, considerable input from several other sources: consultation with the group members' individual therapists, with other members of the ward staff about the impact of the group on the patients, and with the group members themselves—at first informally and finally in a systematic research project.[8]

The present model has been used in hundreds of meetings by me and by my colleagues. It appears to offer a systematic, coherent, and effective structure for the group session. When beginning to lead inpatient groups, I, like most inpatient group therapists, had a sense of the group being out of control, of patients being too ill to profit from a group, of my being overwhelmed with the problem of the rapid turnover of membership. My impression is that the use of this model greatly enhances the effectiveness of the inpatient group. Even the less satisfactory meetings still offer patients something of value, which generally unfolds in the following meetings or elsewhere in their therapy program. Of course, there will always be occasional meetings that seem entirely unproductive. Generally, however, such meetings occur in an unusually unmotivated, resistant patient population, and the lack of work in the group is paralleled by its members taking little or no part in any of the ward therapeutic activities.

Chapter 6

The Lower-Level Psychotherapy Group: A Working Model

The lower-level psychotherapy group, while less complex than the higher-level group, is neither less effective nor less necessary in the inpatient group therapy program. Every acute inpatient unit will have patients who cannot function in a higher-level group: they may be too agitated, too confused, too fragmented or regressed to meet even the modest demands of the group I described in the previous chapter. But these patients can benefit from a therapy group specifically designed to meet their needs and to embrace their level of functioning. The task of this chapter is to describe a model of group therapy for these more poorly functioning patients. I offer this model, just as I did the one in chapter 5, not as a precise blueprint for others to trace but as a teaching vehicle

4

GROUP THEORY AND OUTCOME

As you develop as a group therapist it will be useful to develop a theory of therapy. How does it work? What is the central aim of the process you are inviting patients to participate in? Robert Stolorow provides a succinct definition of psychoanalytic process as the *unfolding, illumination*, and *transformation* of subjective experience. An individual theory like this will then need to be thought about in terms of the group matrix that Foulkes developed and the anti-group as conceptualized by Nitsun. One of Lou Ormont's arguments for group is that the group is a more powerful agent for change than any one individual.

As your theory of group therapy develops it will also be useful to acquaint yourself with the growing literature that offers empirical support for the effectiveness of group psychotherapy. AGPA has submitted a report to the Surgeon General on the effectiveness of group treatments: http://www.groupsinc.org/stdnt/sgr1.html.

GROUP ANALYSIS: GENERAL PRINCIPLES

Dennis Brown

S. H. Foulkes (1899-1976) developed Group Analysis from a background in medicine, Gestalt psychology and psycho-analysis. Contact with sociologists furthered his interest in the effect of context on individual development and functioning.

The following principles are derived from his writings:

1. The essence of man is social, unconsciously as well as consciously.

2. The origin of dis-ease is between people. Neurosis is individualistic and group destructive because it originated in incompatibility between the individual and his original family group.

3. Neurotic symptoms disguise what cannot be expressed within relationships. They are therefore autistic expressions of patients' conflicts, not articulated and therefore inaccessible to memory or expressions.

4. Therapy involves translation into shared communications. Understanding by other groups members is only possible when energy invested in symptoms is translated into shared communication.

5. Disturbances come to be located in the group matrix.

6. Collectively patients constitute the norm from which individually they deviate. Hence normal reactions are reinforced, abnormal reactions modified.

7. All are actively engaged in treatment. All participate, respond, understand and interpret; the conductor strives to deepen and extend the expressive range.

8. The conductor leaves as much as possible to the group.

9. Everything that happens involves the group as a whole as well as individuals. The individual is a nodal point in the group matrix, a spokesman for the group as well as for himself.

10. All communications are relevant; e.g. verbal and non-verbal, conscious and unconscious.

11. Communication takes place at several levels: (a) Current relationships; (b) Individual transference relationships; (c) Shared and projected feelings and fantasies, often bodily and from early, pre-verbal stages of development; (d) Primordial level of archetypal universal images.

12. The aim is insight plus adjustment, through "Ego training in action". This is achieved by interaction of social processes (including Socialisation, Mirror Reactions, Condensor Phenomena and Resonance) and the modification of the individual resistances and defences. In the group, Ego boundaries can be loosened and individuals can re-discover and re-define themselves. More of the person and their energies can be made available for creative expression of themselves and involvement with others.

READING LIST

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5

GROUP AND SUPERVISION CONTRACTS

The issue of written contracts for group treatment is debated. Some argue the contract should be implicit and talked about in the group as the issues of confidentiality, attendance, etc. come up. Others find it helpful to include a written contract. Included here are some examples of written contracts and the beginning of a supervisory contract.

SUPERVISORY CONTRACT

Attendance:

You are expected to attend each session, be on time, and remain throughout the session. Let your supervisor know if you plan to be absent or have to be late.

Process:

You are in supervision to express all thoughts and feelings you have about the work. Scott Rutan mentioned once that the most competent supervisee is the one who can make the most mistakes during the years of supervision.

Co-Therapy:

Experience tells us that it is useful to pick a co-therapist that has a similar theoretical outlook as you. You will be spending a lot of time together so pick someone you like. The co-therapy relationship need not be perfect just as supervision need not be perfect. The difficulties that inevitably arise in the co-therapy just need to be worked on openly in consultation with your supervisor and group.

GROUP AGREEMENTS

1. To be present each week, to be on time, and to remain throughout the meeting.

2. To work actively on the problems that brought you to the group.

3. To put feelings into words, not actions.

4. To use the relationships made in the group therapeutically, not socially.

5. To remain in the group until the problems that brought you to the group have been resolved.

6. To be responsible for your bills.

7. To protect the names and identities of fellow group members.