Psychodynamic Group Therapy: A Multiple Treatment Approach for Private Practice

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Group psychotherapy is an effective modality for treating psychiatric patients that has been underused by psychiatrists while other mental health professionals have been using it extensively.

In the last 10 years, the amount of psychotherapy—especially group psychotherapy—being done by psychiatrists has been questioned. In the 1988 Directory of the Illinois Psychiatric Society, only 49 of the 1450 members listed group therapy as a treatment modality. In the past two decades, the number of psychiatrists in the American Group Psychotherapy Association has decreased from 46% of the membership to 24%, and this figure keeps dropping. Newly trained psychiatrists seem uninterested in practicing group psychotherapy and are receiving very little training in group psychotherapy. In reviewing recent psychiatric journals, few articles on group psychotherapy were found.

Why has group psychotherapy been underused by psychiatrists? Several reasons can explain why. Among them stands the new psychoanalytic discoveries, the trend of remedicalization of psychiatry and, consequently, the deemphasis on psychotherapy. Because a wide referral base is needed, it is difficult to start a group in a solo private practice. However, in order to deal with the multifactorial influences on psychiatric disorders, treatment should be comprehensive.

The underlying human subjective aspects of the relationship between the patient and the therapist, which we refer to as transference and countertransference, have been carefully studied and demonstrated to be important considerations in any treatment approach, whether primarily biological or primarily psychosocial.

THE GROUP PSYCHOTHERAPY PROCESS

As patients react and develop relationships among themselves and with the therapist, the group leader persistently wonders why, how, when, and to whom the patient is talking. These interrelating vectors in the “here and now” of the group session are examined in the context of the multitransferential and countertransferential relationships developed in the group. The connections
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After much hesitation (“Is he giving up on me?” and “Am I really going crazy?”), he agreed to take alprazolam. Also, since FDA approval, he was started on clomipramine for his obsessive-compulsive disorder features. Both this patient and the other members of the group understood that CO has biologic vulnerabilities in addition to his psychosocial problems.

Case 2
RT, age 31, came for treatment because of feelings of inadequacy and difficulty in standing up to his domineering father, with whom he worked. He was ambivalent about breaking away from the family business. He also reported having anxiety while driving a car or in other places, “out of the blue.” He responded well to alprazolam, which was later combined with imipramine. However, he, too, was included in the group therapy to resolve his relationship with his father and other men.

Case 3
FS, age 44, was a competent management consultant who sought further therapy after having seen other psychiatrists and psychologists for over 15 years. He was satisfied with his business success but did not have a sense of belonging. He felt alienated from his family and ethnic background and lacked a sense of identity. He felt lonely and anhedonic. He could neither live with his wife nor decide to marry his mistress. With the recent death of his mother, he became more “paralyzed” and could not consider making any changes. He became increasingly depressed, unable to sleep, and preoccupied with guilt. He reluctantly tried various antidepressant and antianxiety drugs but would prematurely give them up because “they were causing side effects.” After a few months, he benefited by using fluoxetine consistently and he continued group therapy with occasional individual therapy sessions. Later, he moved into a condominium, began the process of getting a divorce, and started therapy sessions along with his wife-to-be.

All three cases point out the need for flexibility and resourcefulness in the treatment of patients. The selection and preparation of patients for group therapy often evolves gradually because these patients frequently start with
individual psychotherapy for at least several months.

Group cohesiveness is the development of a binding relationship among the group members that is essential for therapeutic effectiveness. The common goals, group spirit, mutual acceptance, and support of group members lead to open sharing of innermost thoughts and feelings.

THE ROLE OF THE GROUP THERAPIST

The group therapist has been described as a figure who embodies the warmth, wisdom, and experience of the old-time family doctor and the psychodynamic skills of the analyst. As in individual psychotherapy, the chief instrument is the therapist's own person. In group therapy, the other members are also therapists to each other.

The group therapist has a multifaceted role of group leader, conductor, facilitator, interpreter, arbitrator, and parent figure. The therapist's participation in the group encompasses a wide range from quietly listening, to being nurturing and empathic, to being direct and confrontative. He or she must be alert to the verbal and nonverbal communications of the patients.

Although the group therapist's interventions are always intended to have a therapeutic significance, one should not stifle human spontaneity or a sense of humor. A therapist should not be aloof, distant, or judgmental nor intrusive, overchallenging, or overzealous. Therapists should avoid being authoritarian, dogmatic, and pedantic. The therapist should be active and positive in his or her involvement. The therapist should emit and evoke acceptance, respect, and hope. He or she should be familiar with the patient's manner of speech but refrain from using it. The therapist should react with simplicity, honesty, and realism while still promoting optimism. Therapists should intervene if physical threat, disruptive acting out, or uncontrollable, destructive expressions take place. The group therapist should have training and supervision in group therapy, with both individual and group therapy experience. This is not only essential but also especially important if one wants to understand the subtleties of transference and countertransference.

THERAPEUTIC FACTORS IN GROUP THERAPY

The therapeutic effectiveness of group therapy is multifactorial. Much depends on the therapist, his or her method, and the patient's needs. The Figure outlines some outstanding therapeutic factors from Yalom's extensive discussion in his classic book, *The Theory and Practice of Group Psychotherapy.*

MANAGEMENT OF COMMON PROBLEMS IN GROUP THERAPY

Problem patients commonly seen in group therapy include the monopolist, the silent patient, and the help rejecting complainer (HRC). In addition, the therapist may need to deal with extra group socialization (fraternization) and combined individual therapy sessions.

**FIGURE**

Therapeutic Factors in Group Psychotherapy

- Providing of information
- Instilling hope and faith
- Finding that others are like us—consensual validation (“We are all in the same boat”)
- Helping each other
- Reexperiencing the conflicts of the original family group in a therapeutic situation—the resolution of disturbing problems stemming from the family of origin
- Learning new socializing techniques
- Modeling behavior (identification)
- Recognizing existential factors, such as sickness, accidents, death—coming to the realization that ultimately life must be faced alone
- Ventilating, abreactions (catharsis) coupled with cognitive learning (the rule in intensive therapy is: no abreaction without cognition; no cognition without abreaction)
- Experiencing group cohesiveness—close relationship among the members of the group and the therapist (if we are loved by others, we can love ourselves and if we can love ourselves, we can love others)
- Interpersonal learning through group interaction—the “here and now” experience in the group as a human laboratory for social living (at a deeper level, it stimulates introspection leading to insight and growth)

The Monopolist

Although the monopolist may be a problem in the early stages of a group, patients eventually feel comfortable with each other and can interrupt anyone who is monopolizing the discussion.

The Silent Patient

It has often been said that the silent patient may profit vicariously. As a rule, the more active a patient is, the more he or she profits from group therapy. The therapist should encourage the silent patient to participate, especially after the initial period. If this continues to be a problem, it may be necessary to have a few concurrent individual sessions to help explore and loosen the block.

The Help Rejecting Complainer

Much has been written about the HRC. He or she can certainly be frustrating. The HRC’s quick reactions are: “You don’t understand,” or “This won’t work,” “I know what you’re going to say,” “I feel I am annoying you,” “I sense disapproval,” and so on. The underlying reason for rejecting help must be worked through with the patient.
The therapist should realize that HRCs really do not trust (transfer- ence) that the help being offered is genuine.

HRCs will often come to a group session with a crisis, such as an impending divorce, bankruptcy, break with a business partner, or the hospitalization of a family member. They will ask the group for an immediate solution for the problem which, somewhere in their mind, they thought would not or could not be provided anyway (unresolved dependency needs). An HRC member of our group remembered how his father used to say, "If you keep crying, I'll give you something real to cry about," and then spank him or her; however, the reason for crying in the first place was not resolved.

**Extra Group Socialization (Fraternization)**

Fraternization tends to develop social loyalty among those patients who become friends outside the group. Avoiding necessary confrontations may hinder the therapeutic use of the group. Similarly, it is the silences that are actually untherapeutic—not the fact that the group members socialize.

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**One of the advantages of group therapy is that one patient can point out another one’s blind spots.**

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**Combined Individual Therapy Sessions**

Combining individual and group therapy sessions may be necessary when:

- conflicts arise in the group that may prompt a member to terminate prematurely,
- an unusual emotional crisis occurs that cannot be contained in the group, or
- other difficult resistances occur.

**SPECIAL TECHNIQUES**

Special techniques, such as the empty chair, sculpting, home assignments, alter ego, psychodrama, and going around can be useful from time to time, especially in the early stages of group therapy. However, in the advanced stages of intensive group therapy, psychody- namically-oriented verbal interaction is the main approach.

**CONCLUSION**

Group therapy is an important modality that can be effective in complementing the multiple treatment approach of psychiatric patients whose disorders fall anywhere in the biopsychosocial spectrum.

**REFERENCE**


**BIBLIOGRAPHY**


