A NON-DIRECTIVE METHOD OF GROUP PSYCHOTHERAPY.[1]

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GROUP PSYCHOTHERAPY, although a method of therapy as yet practised little in Australia, has come to stay, if one may judge from the considerable research in this direction overseas. It is therefore of considerable importance for us to consider the possibilities of this new field of therapy. It has certain attractions—firstly from the point of view of research into the effects of group tensions on individuals, and secondly in the direction of bringing therapy to greater numbers, which latter has always been an important aim of medical practice. There is also the prophylactic aspect, always of interest to medicine—namely, to what extent can suitable group therapy in young people reduce the possibilities of breakdown in later life?

[1] Read at a meeting of the Australasian Association of Psychiatrists on August 22, 1956, at Brisbane.

The task that faces the psychotherapist is to develop some system in his technique. This is difficult, because he is dealing with intangibles such as emotional states, mental attitudes and neurotic symptoms. A system of rules of procedure tends to give an undesirable rigidity to a situation which is primarily one of emotional interplay. On the other hand, a complete absence of rules means that the therapist is relying entirely on intuition, with the result that he is never sure what to say next, and that he has little idea of whether what he does say is essentially interpretation, reassurance of the patient, reassurance of himself, or defensive for his own sake. An example of the last-mentioned occurs when the therapist says something that unconsciously steers the patient away from a topic that disturbs the therapist himself.

Thus what we have to find is some systematic approach which is not too verbose, bookish and theoretical (this would only stultify the emotional aspects of therapy), and one which will, as far as possible, protect the therapist from making too many errors in the way of accidentally introducing his own unconscious problems into the situation.

It is with these principles in mind that I shall try to describe a non-directive form of group therapy, which may be of interest not only to psychotherapists, but also to those general practitioners who have a particular leaning towards psychological problems. It is from amongst the patients of a general practice, in which the widespread occurrence of minor neurotic disorder is so apparent, that really satisfactory therapeutic groups may be formed.

How far the technique here described can be extended into an analytical approach will depend on the innate capacity for insight of the therapist, and on the degree to which this has been enhanced by any analytical training he may have had.

But first let us say something about patients likely to respond to group therapy. Psychoneurotics and those with uncomplicated psychosomatic disorders are suitable. The question of having different types of psychoneurosis in the same group is not so important as it may seem from the point of view of the ultimate therapeutic result. However, research on groups comprising patients suffering from the same condition, compared with groups whose members have different clinical conditions, may throw some light on the best group arrangement for obtaining the maximum therapeutic efforts in any particular disorder.

Prepsychotics and psychotics may raise special problems. The first often show an incapacity to withstand the tensions engendered by the group, and the second often have not sufficient capacity for cooperation to attend regularly on a voluntary basis. Patients in both these categories may therefore require additional private psychotherapeutic sessions and often need some degree of supervision between sessions. There is, for instance, sometimes a danger of a schizoid patient's becoming overtly psychotic.

I should say that anything from two to eight patients constitute a group that can be worked with fairly well. As the numbers rise higher the treatment tends to become unwieldy, and provides too much opportunity for inhibited and withdrawn patients to take refuge by hiding themselves away in the "crowd".

Sessions should number two per week and should last approximately one hour each. It matters little whether the groups are of one sex or mixed, because similar problems will crop up in any sort of group. I think it important that in the early stages of treatment it should be made clear that the only complete freedom that is given in the group is in speech, and that physical contact of any sort, either in affection or in anger, is not allowed. I should like to point out here the danger of having in a group patients who are too strongly paranoid or hypomanic. In these persons the ego-control of aggression is rather precarious, and they may be relatively easily provoked to violence. Early in the treatment it should be made clear that it is expected of every member that he regard what is discussed in the group as confidential. After the preliminary introduction of the group members to one another, it should briefly be explained that they are permitted to talk about anything they like, in any way they like, and that this free discussion, together with the therapist's comments from time to time, constitutes the treatment.

This often produces nothing but an awkward silence. In this case the therapist can put into words the fact that they experience some difficulty in throwing off the usual restraints of conventional social gatherings. This is not exactly telling them anything new, for they all feel it acutely; but it clarifies the fact of this unexpected and somewhat disturbing permissiveness, and sharpens their awareness of an inner resistance against taking advantage of the freedom to talk as they wish. This, more often than not, is sufficient to lead to a discussion of the difficulties of talking freely, before others, of intimate matters.

However, it will still be some time before the group will talk sincerely of their problems. All sorts of resistances will emerge to stall off the anxiety-provoking revelations.

It is, of course, impossible in this contribution to deal in any way exhaustively with all the technical problems that occur during the course of treatment; but I shall try to give some idea of the more common, and often recurring, resistances and difficulties that will inevitably crop up and will have to be handled in some way or other. I realize that each therapist will develop his own ideas on just how to cope with these problems, and will do so largely according to his own psychological make-up. Thus, what I have to say should be regarded as rather tentative, and intended merely as a guide in what is still largely a scientific wilderness.

With regard to the chronically silent patient, the therapist should not be unduly worried about this if he is coming to the group regularly. Pointed references to his silence, however kindly, should be avoided, since obviously his unconscious anxiety is great, and he is trying to hide himself away. If he is singled out, he feels it as a signal for a group attack on him, and he may not come again. He usually takes a remark about his silence from another patient with less anxiety, and this will certainly come sooner or later. However, if there are several silent ones, the therapist can safely help by addressing them together and remarking that there must be some special difficulty here.

As far as possible, the therapist should avoid being tricked into answering a lot of questions and giving advice based on them. Sometimes it is necessary to do so, however—for example, in the instance of a person who describes symptoms and then asks if they are a sign of a certain disease. Here he can be reassured or advised to seek a medical examination. Most other questions can be dealt with most effectively by going into the patient's need to ask them. For instance, why does the patient have to ask how to deal with a difficult work mate? Why cannot he decide himself what to allow his children to do or not to do? This approach usually results in a discussion of the patients' fears, doubts and conflicts, and can often be led round to what they expect of the therapist—that he should take their responsibilities off their shoulders, that he should be a better parent than their own, and so on. If trivial talk continues for some time, the therapist should point it out, and this is usually enough to prompt somebody to bring forward a topic that means something for him emotionally. In this case we sometimes find that the others remain silent as if completely unaffected. This attitude, one finds, is defensive. When a person talks of deeply felt matters, such as grouches against spouse or parents, frustrations in his ambitions, difficulties with the opposite sex, autoerotic experiences and conflicts and so on, this always strongly affects the other members of the group despite their silence; hence their failure to express what their reactions were, and what they thought of the subject raised, can be pointed out.

An exhibitionistic, aggressive patient who monopolizes the time of the group session will eventually make some of the others impatient and restive. However, the abreaction can be helped along by asking this person why he needs to hold the floor so much, and by asking the others why they

so readily let him do so. This will often bring to light their fears of being aggressive even to the extent of standing up for their own rights. The point becomes clearer to them that they are afraid that if they give any expression at all to aggression, it may get out of hand altogether.

Group therapy in a hospital of in-patients has features which distinguish it from that with independent patients living in their own homes. It is this latter type of group work with which my remarks are mostly concerned. It seems to me that in this case it is wise to discourage social contact outside the group meetings, which, of course, is not possible with patients resident in a hospital. Social contacts outside the group tend to increase the difficulty of candid discussion inside the group, especially when mutual criticism is involved. Such contact often leads to the breaking off of treatment.

The new patient, to be introduced to a group which has already been working for some time, should be interviewed privately on a number of occasions first. This helps him to develop a good *rapport* with the therapist, which enables him to withstand the anxiety provoked in the early stages of his group experience.

You will see that I have said nothing about symbolic interpretation, and the transference. It was not intended to describe analysis in groups, but rather to discuss certain factors in a technique which might facilitate a mild continuous abreaction through talking. The therapist's task is thus seen as one in which he tries to play the part of a catalyst, keeping his own idiosyncrasies out of the picture as far as possible, and encouraging the venting of feelings on a verbal level, and the free discussion of previously prohibited topics. At least in the milder neuroses and psychosomatic disorders I think some such technique as this can produce gratifying results.