GROUP PSYCHOTHERAPY

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ANXIETY AND RELATED DISORDERS

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There are many methods of attitudinal change. Some people are influenced by religious healing or religious conversion. Some respond to placebo, while others have succumbed to forms of brainwashing. Jerome Frank (1961) has written about these approaches in great detail, but psychotherapy remains the most effective method of attitudinal change (Strupp, 1973). Group psychotherapy, which harnesses the talents of both patients and the trained group leader, tremendously reinforces the effects of individual psychotherapy.

Today, the practicing professional and the patient in need of psychotherapy find that there is pressure to expedite the process of psychotherapy—to achieve the "quick fix." The pressure comes largely from insurance companies who are pushing the concept of "cost containment" or "managed health care" with a strong emphasis upon biological treatment for psychological problems. As we move toward the real possibility of government rationing of all types of health care, there is pressure to emphasize short-term interventions as a form of psychotherapy. Indeed, some practitioners emphasize that all psychotherapy should be short-term with patients returning through their lifetimes for additional psychotherapy

as needed. There is the real possibility that psychotherapists, under the mandate of "curing" emotional problems in 10 or 20 visits, will begin to create a new diagnostic procedure that is wedded to economics rather than the real needs of people in distress.

There are many self-help organizations. For the most part, they effectively relieve the isolation and loneliness that so many emotionally distressed people feel. The patient and professional psychotherapist may ignore the "political agenda" that many self-help groups (which describe themselves as group psychotherapy) proselytize. For example, a self-help group that is devoted to the radical feminist view will obscure or ignore the underlying pathology that is part of the patient's psychic distress. People in distress may be encouraged to look for simplistic solutions to complex problems. As mentioned earlier, the current push to pharmacological intervention may relieve the manifest symptoms but will not resolve intrapsychic distress or problems of relating interpersonally.

This chapter concentrates on the group treatment of anxiety disorders. The current Diagnostic and Statistical Manual of Mental Disorders III (DSM-III-R. rev.) lists six categories of anxiety disorders. These are panic disorder (PD) with or without agoraphobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), social phobia (SP), and simple phobia. The recommended approaches are

education, psychotherapy (psychodynamic), behavior therapy, cognitive therapy, and pharmacological approaches.

The emphasis in this chapter will be upon psychodynamic intervention. There will be some attention given to the rationale and wisdom of combining pharmacological approaches with group psychotherapy approaches.

Therapists who work psychodynamically often differ radically in their ways of working with anxious patients. This is related to their perception of the origins and meaning of anxious behavior. But all psychotherapists agree on the fundamental significance of anxiety in psychopathology. Anxiety is viewed as some type of threat to the self-image. The more traditionally trained psychotherapists define affects as a combination of ideas and experiences of pleasure or unpleasantness. When the affect of unpleasantness becomes combined with an anticipation of danger or disaster, the emotional response is labeled anxiety. If the anxiety continues over prolonged periods, it often leads to depression. The traditionally trained psychotherapist looks for childhood origins as an approach to resolving the disabling effects of anxiety.

There are many different aspects of anxiety. The anxieties of failing in one's responsibility is different from situational anxiety (often referred to as a phobic response). Anxiety about losing one's marital partner is different from anxiety about losing control over one's behavior.

Freud's early model of intervention was based on biology and the physical sciences, related to his early background as a neurologist. He moved on to an awareness of the patient's inner world and to the psychic realities of the inner world. Freud at the outset conceptualized all anxiety as being caused by repression—the libido is blocked or repressed and this converts into anxiety.

As Freud continued his work, he realized that anxiety *caused* repression. This led him to explore the sources of anxiety and to probe more deeply into the realm of psychic conflict. He moved from his example of mechanical blockage to the concept of psychological conflict. He also came to realize that aggression plays a large part in both guilt and anxiety.

In Europe, neurosurgeons who follow a biological approach have used radical interventions for patients who have had many years of incapacitating anxiety disorders (Mindus & Nyman, 1991). This brain operation, known as capsulotomy, appears to be a very drastic intervention and the jury is still out as to the long-term results of this type of intervention. There has been some degree of immediate relief.

Many psychotherapists who work with groups are strongly influenced by Harry Stack Sullivan (1940, 1953a, 1953b), an American psychoanalyst who postulated a view of anxiety based on the idea that it is interpersonal in

nature. He stated that anxiety is induced or “caught” from people who were or are significant figures in a person's world. Sullivan stated that three sets of needs had to be met for each person and depending on how these needs were met, anxiety would result—the degree of anxiety related to the unfulfilled need. The basic set of needs according to Sullivan consisted of the biological (satisfaction/fear), interpersonal security (anxiety), and interpersonal intimacy (love/loneliness). The psychotherapists who agreed with Sullivan, such as Erich Fromm (1955), Rollo May (1967), and Frieda Fromm-Reichmann (1950) expanded on Sullivan’s view of anxiety. They stressed the need for personal fulfillment—personal expansion and self-knowledge. People who feel unfulfilled often express feelings of anxiety or loneliness. Fromm-Reichmann (1950) went so far as to state that “psychological death” is the end result of people who have not fulfilled themselves and have lived with constant dread.

The other need, personal orientation, a freedom from chaos, has been stressed by Erich Fromm in his writings (1947). He stressed the individual’s need for some “rootedness." If this does not occur, people live life in a state of apprehension that leads in turn to what has been called chronic anxiety. Karen Homey also stressed the interpersonal aspects of anxiety (1939).

Current approaches to treatment of anxiety that emphasize psychodynamic inquiry are based on the work of object relations theorists

(Guntrip, 1973; Winnicott, 1963) and practitioners who follow the selfpsychology approach of Kohut (1971). Each theoretical school emphasizes an approach to anxiety that consists of containing the anxiety, reassuring the patient and ultimately precluding further disabling anxiety reactions.

In Latin America, as well as some European countries, group therapists often use techniques that follow the theoretical constructs of Bion (1959) who was strongly influenced by Melanie Klein and her concepts of personality development. Bion described all groups as shifting back and forth in certain regressive patterns. Bion called this the *basic assumption* (dependency, fight-flight, pairing) and *work* groups. He elaborated upon the complex intertwining between these two forms of group process as the group leader studied any segment of group interaction. A *basic assumption* group may be seen as a group of children who want immediate satisfaction of their needs or what they believe to be their needs. The *work group* requires concentration and organization to be fully productive and this is where the group leader is very important. Another concept that Bion used is valency, referring to the patient's willingness to join with the group in the *basic assumption* (dependency, fight-flight, pairing) (Rioch, 1970). What Bion was postulating was a vision of the human being. In this respect, like all seminal thinkers, he had a vision of humankind.

Current research indicates that some people are more vulnerable to

stress than others. Research that utilizes positron emission tomography (PET) indicates different levels of energy use in the limbic system of the brain leads to a panic disorder associated with fear and anxiety. It appears that some people are born with a genetic predisposition, which may effect the chemical system of the brain, so that they find difficulty in coping with stress and the chaos of everyday life. These are people often referred to as "high strung." There is controversy over whether or not stress experiences in childhood or adolescence may sensitize the brain's system so that these people are susceptible to generalized anxiety—a persistent nagging feeling that something is wrong. This feeling often escalates into panic attacks.

The current physiological research leads back to childhood and the impact upon the individual. A combination of drugs and psychosocial approaches appears to be effective with 80 to 90% of people who come for treatment. The approach must be tailored to the individual. While it is wise to be consistent as to the approach one will use with a patient, it is equally important to recognize that options are available.

The psychotherapist must recognize the physical symptoms that accompany anxiety: shortness of breath, faintness or dizziness, rapid heart rate or palpitations, nausea and stomach pain, trembling or excessive sweating, a feeling of unreality, numbness or tingling of extremities, chest pains and finally the most frightening—fear of "going crazy" or total loss of

control. Freud's daughter, Anna Freud (1966) differentiated between anxiety and fear. Fear is related to an individual's response or attitude to real dangers that threaten one from the outside. *Anxiety* is a reaction to *internal* threats that come from one's psyche. *Anxieties* may develop into phobic behavior. *Fears* do not.

Experienced group psychotherapists do *not* ignore options of psychotherapy. Years of experience have indicated the enormous impact that group psychotherapy has when it is practiced by *experienced* group leaders.

The history of group psychotherapy goes back to the beginning of recorded time, since every religious movement that reaches groups of people might be described as group psychotherapy. This chapter is concerned with systematic approaches using the group method to relieve emotional problems, specifically anxiety reactions.

Joseph Hersey Pratt, an internist who practiced in Boston, Massachusetts, is considered to be the founder of contemporary group psychotherapy (1953). He began his work in 1905, working with tubercular patients who were discouraged and disheartened—in short, despairing and anxious. Most of Pratt's patients were of limited educational background and were victims of social disdain, since tuberculosis was considered a social disease. In many ways, the psychological climate was quite similar to what

AIDS patients experience today.

As Pratt lectured, inspired, and cautioned his group of patients, he found that the spirit of camaraderie overcame whatever religious, ethnic, or racial differences existed among the tubercular patients. His work confirmed the writings of the French psychiatrists, Dejerine and Gauckler (1913) who wrote at the beginning of the 20th century that psychotherapy consisted mainly of the beneficial influence of one individual upon another. Another pioneer in group psychotherapy, Trigant Burrow (1927) was excited about the use of group approaches to emotional problems. His work was not greeted with great enthusiasm by Freud, to put it mildly. Freud viewed Burrow's work as an effort "to change the world." So Burrow worked in isolation as did Moreno (1946), the founder of psychodrama, a group psychotherapy approach that utilized a theatre method to resolve emotional problems. The various group approaches have been covered by this author (Rosenbaum, 1976) elsewhere, but it is important to know that whatever approach is used, group psychotherapy remains an effective way of treating people who are disabled because of anxiety.

Whatever labels are used in describing a group psychotherapy intervention: transactional analysis, psychodrama, interactional, interpersonal—there are basic principles at work when patients meet in a group led by a trained professional.

The group treatment of people who are anxiety-ridden may range from a repressive-inspirational approach with the emphasis on support and reassurance, to a regressive-reconstructive approach, where the emphasis is to elicit information about the original traumas that have led to the current problems.

A group that is largely repressive-inspirational in nature will be formed in the belief that the group members have a common problem. The emphasis will be upon support. The group leader will be directive and actively controlling since group members are perceived as "not knowing." The hope is that group members, once they have learned how to handle the overt problem, will no longer need to meet with one another. The group leader will be active, directive, inspirational, and advice-giving. The emphasis will be on current reality. Approaches that are cognitive (intellectual), behavioral, and educative represent the repressive-inspirational aspect of psychotherapy. If a group is composed of post-coronary patients who are anxiety-ridden about future life, support and reassurance are stressed. The group may be considered homogeneous in nature. The goal is to help with the transient anxiety. If male group members are concerned about their sexual activity, reassurance is appropriate as well as information and direction. If the ostensible anxiety about sexual activity masks a long-term anxiety about sexual impotence and fears of relating to women, the goals moves toward regressive-reconstructive group psychotherapy where the treatment is

directed toward personality change. The woman who has had a mastectomy and is deeply anxious and troubled about her sexual attractiveness may be a suitable candidate for a short-term therapy group that is oriented toward reassurance. But if her mastectomy caps a long-term dissatisfaction with her body as well as her personality, her anxiety is of a more profound nature, and she is best served by becoming part of a longterm group that is totally heterogeneous, as is the outside world, and includes men and women and every variety of race, culture, and social class, as well as any emotional disturbance. This lends itself to a "talking" type of group psychotherapy. In this kind of group, members mature and leave the group and new members are introduced. Like life, the group never ends. Symbolically there are births —members entering the group—and deaths—actual or those who become discouraged about group psychotherapy and leave.

The group leader promotes the expression of affect in this type of group psychotherapy and encourages the re-enactment of past historical events, especially intrafamilial relationships. This is all related to behavior in the therapy group. Dreams, as well as fantasies and delusions, are brought to the group where they are discussed and explored. The immediate interaction of group members is analyzed as well as the personality mechanisms at work in the interaction. The group leader helps clarify the compulsive mechanisms at work and points to their recurrent nature. This is intensive group psychotherapy.

Most of the current controversies that relate to the use of group psychotherapy are concerned with the emphasis that some group therapists place upon the "group as a whole." In this approach, there is minimal attention given to the individual and intrapsychic exploration, and much emphasis is placed upon the curative value of the group and individual participation in the group. Alexander Wolf (1949), an early worker in the field of group psychotherapy, stressed that working with a group replaces the ideal of the single *parent-psychotherapist*. Instead of the omniscient ego ideal of the individual psychotherapist, the patient is presented with a group "with whose common aims he must align himself." The group precludes the evasion of social reality, which may exist in the one-to-one relationship of individual treatment. According to Wolf, "participation in the group helps to destroy the false antithesis of the individual versus the mass by helping the patient to become aware that his fulfillment can only be realized in a social or interpersonal setting." Yet in spite of the fact that Wolf apparently recognizes the importance of the "corrective emotional experience" (Alexander & French, 1946), which includes a corrective social experience, he and others who agree with him remain hostile to a group therapy approach that stresses group dynamics. He asks, "How do group dynamics achieve a healing objective?" (Wolf & Schwartz, 1962). In his most recent work (Wolf & Kutash, 1991), he remains antagonistic to the emphasis upon group dynamics in the "group as a whole" approach. He has attempted to work toward an egalitarian ideal in

group therapy. His goal was the diminution of his own leadership role. He aimed for the distribution of authority, power, and leadership among his group of patients. He stressed that the *group qua group* cannot become the means by which its members resolve *intraphysic* difficulty. He stressed that he does not treat a group, but rather the individual in interaction with other individuals.

Wolf's approach is in marked contrast to group therapists such as Yalom (1985), a practitioner and researcher, who stresses *interaction* rather than the *intrapsychic*. Wolf's emphasis upon the individual within the group approach ignores the possibility that the group therapist's interpretation of the psychodynamics of the individual patient (or the transference at work) may encourage a certain degree of passivity on the part of group members as the group leader is seen as most expert. This "passivity" may be seen as a phase the group goes through until group members move toward autonomy.

The most quoted writer in group psychotherapy (Yalom, 1985) is fully wedded to an interactional approach to work with groups. He supports the ideas of concurrent group and individual therapy, the use of co-therapists (Roller & Nelson, 1991), the use of videotape (Berger, 1978), and a written summary that is shared with the patients.

Gill and Brenman (1948) stressed that the therapist's understanding of

"emotional intercommunications" is central to psychotherapy. They noted that sound movies or other technical aids (long before the advent of video and other technical devices) could not replace the psychotherapist's hypotheses, predictions, and goals about the course of treatment. These "may prove the central methodological tool in clinical research." Their comments remain relevant today. Rosenbaum (1978) has set forth the issues of privacy and privileged communication that are involved if videotape techniques are used as part of group psychotherapy.

In the early editions of Yalom's book, the concept of transference was largely ignored in his approach, but in time, Yalom finally elaborated upon this important aspect of all psychotherapy. Yet he continues to ignore the aspects of countertransference—the therapist's response to the patient based upon unresolved problems of the therapist, having little or nothing to do with the patient. The essential difference between the analytic group psychotherapist and the group therapist who stresses an interactional approach is the emphasis placed upon countertransference as part of the healing process. Yalom has come to the position that ". . . cure is an illusion ... the passing years have taught us that psychotherapy affects growth or change. . . ." It is just possible that therapists are beginning to be more thoughtful about issues such as responsibility, mortality, and the consequences of our own behavior— issues that have been avoided all too frequently. Rosenbaum (1982) has stressed in his own writings, that patients

must be confronted with the ethical issues involved in living. This does *not* mean that a psychotherapist is to be a moralist, a task best left to the clergy. But there are ethical issues involved in all of life's decisions, and this is a proper area for group discussion, without the issues becoming politicized.

One group psychotherapy approach that has experienced a renaissance, especially in Europe and South America, is Moreno's technique of psychodrama, which is a form of group psychotherapy. Moreno's approach is action-oriented and his students have attempted to change patterns of social relatedness. Modifications of his technique include sociodrama, role playing, sociometry, and axiodrama. Moreno described psychodrama (1946; 1957) as using five instruments:

1. *The stage* which represents an extension of life beyond the reality of life. The stage is circular and may be equated with the aspiration levels of an individual moving from one circle of life to another.

2. *The patient* who is requested to be himself or herself on stage and to share private thoughts, to act freely, and not to perform.

3. *The director* who analyzes, interprets, and integrates the perceptions of the audience. The director keeps the action moving and maintains rapport with the audience—an integral part of the group process. The director may attack, criticize, or engage in humorous repartee with the patient.

4. *The auxiliary egos* who are a staff of people who serve as therapeutic actors, extensions of the director who portray real or imagined people in the patient's life.

5. *The audience* which has a double purpose. It serves first as a sounding board. Since it is a heterogeneous group, the audience is spontaneous in its responses. The patient, immobilized by anxiety, is helped by the accepting and understanding audience who confirms for the patient that all of us have been anxious to some degree. Secondly, the anxious patient also helps the audience as the patient reenacts the collective problems of audience members.

Moreno believed strongly in the importance of group participation. He stated that he had rediscovered the therapeutic aspects of the Greek drama and its effects upon mental catharsis. He stated, ". . . the psyche which originally came from the group, after a process of reconversion on the stage—personified by an actor (THE PATIENT)—returns to the group—in the form of psychodrama . . ."(1946).

Whatever theoretic format the group therapist follows, whether psychodynamic or behavioral, the most important aspect is the group therapist's capacity to cope with the manifest anxiety of the patient. We are clearly in the area of countertransference. Experience has indicated that the matching of the patient and the therapist is central to the therapeutic process. The psychotherapist who makes first contact with the anxiety-ridden patient

serves as the transition point to the group. It is the patient's trust or distrust of this individual that will make therapy, at least at the outset, feasible or a failure.

Every patient, when the idea of a group is suggested, views the therapist as rejecting the one-to-one relationship. While the patient may not overtly express the feeling of being rejected, the therapist must be aware of this and believe strongly that the group experience is helpful and central to the patient's recovery and change. The patient will often believe that the group experience is second class in nature and experience the idea of group therapy as abandonment. The anxious patient often feels that his or her suffering is not significant enough to warrant the valued one-to-one relationship. It is possible that the patient has experienced a paucity of one-to-one experiences in early life and needs prolonged preparation before the idea of a group is brought to the fore. The anxiety-ridden patient is often dismissed as being attention-seeking or crying "wolf" much too often. But the pain and fear is real and the symptoms *are* disabling.

The psychotherapist is easily caught up in the symptomatology of the anxious patient and may rush to pharmacological intervention, but this type of intervention is only indicated when the anxiety is so paralyzing that it interferes with systematic psychological work in the group. Karasu (1982) has pointed out that medication is indicated for a "state" and psychotherapy

is preferred when there is a "trait disorder" that has been long lasting. Group psychotherapists who are firmly wedded to a psychoanalytic tradition often express the opinion that therapy will be "contaminated" if medication is proposed, except in very critical situations. But current experience indicates that patients who are encouraged to discuss their medications openly as part of the group process will profit from an ancillary method of helping them cope with disabling anxiety. A more important problem is whether the group therapist should be the person who prescribes the medication. Does this influence the course of treatment and lead to too much dependency on the patient's part? The danger is that group psychotherapists may rush to the use of medication for patients as a way of coping with the therapist's anxiety about the patient's anxiety.

Group psychotherapy continues to be an effective method of treating patients who present anxiety problems that are disabling. It is critical that the therapist be aware of his or her need to be overprotective and directive. Anxiety-ridden patients need careful preparation for the group, otherwise the group becomes a life-long "crutch" and no substantial internal psychic change has occurred. Life-long dependency characterizes many of the self-help groups. Yet, there may be individuals who are so vulnerable through the years that they need the support of a subculture. But this is *not* group psychotherapy where the group is led by a professionally trained therapist.

Unlike Yalom, this writer believes that people are capable of dramatic change. The use of the word "cure" leads us into a blind alley. It makes more sense to use the word "change" which means becoming "something different." The word "help" means aid or support. Much of "change" in the patient depends upon the motivation and skill of the group psychotherapist. As research continues in the field of psychotherapy, we will find answers as to why some patients complete a process of group psychotherapy so successfully and others fail to achieve any significant growth. My own surmise is that the differential diagnosis is of critical importance. All too often, patients are "swept" into groups. Most important is the careful matching of the therapist and the patient and what earlier writers have called a "therapeutic alliance" (Zetzel, 1956) or a "working alliance" (Greenson, 1967). This is especially true with the anxiety-disabled patient who feels immobilized. The support, reassurance, and encouragement to explore, all of which exist in an effective group, bodes well for the patients who are diagnosed as suffering from anxiety disorders.

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