

Group Therapy

Combined with

Individual Psychotherapy



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Group Therapy Combined with Individual Psychotherapy

In view of the confusing ways in which therapeutic group approaches have been depicted in the mental health field, the term *group psychotherapy* will be employed in this chapter in its strictest sense, as connoting an intervention modality wherein a specially trained professional practitioner “. . . utilizes the interaction in a small, carefully planned group to effect ‘repair’ of personality malfunctioning in individuals specifically selected for this purpose. A clinical orientation, which includes a diagnostic assessment of each group member’s problems, is part of this picture. Furthermore, each patient is cognizant of the psychotherapeutic purpose and accepts the group as a means to obtain help in modifying his pathological mode of functioning” (1).

The group psychotherapy field distinguishes between two distinct patterns of utilizing group psychotherapy for a patient who is concurrently receiving individual treatment. The first pattern, employed with the greatest frequency, involves the “combined” use of individual and group treatment by the same therapist. The second, termed “conjoint” therapy, calls for the cooperative utilization of the two treatment modalities for a given patient by two different therapists. The respective technical issues posed by these two similar, yet distinct approaches will be delineated at a later point.

It must be stated here that while we share the belief of most clinicians that both individual and group psychotherapy have their respective places in the clinical realm and that there are many specific circumstances where individual psychotherapy alone is not enough for certain kinds of patients, this view is not necessarily shared by others, in fact, as we will note in the review of the literature, there are a number of authorities in the group psychotherapy field,

especially from the so-called “British School,” who conversely advocate the *exclusive* use of group treatment for most patients and who are principally opposed to simultaneous dyadic interventions in any form. These latter group therapists frequently view the introduction of individual sessions as a dilution of the potent group transferences and as a resistance to the group treatment medium.

While combined therapy has been also employed with children and with adolescents, our chosen focus here will be on the treatment of adults only.

Review of the Literature

It is noteworthy that well over 50 contributions dealing with combined individual and group psychotherapy appeared during the fifties and sixties. The virtual absence of more recent publications on this subject is probably due to the fact that, like group psychotherapy employed exclusively, these once new and controversial modalities have by now become an accepted part of the mental health scene.

Beginning with a 1949 paper by Wender and Stein (2) there were a number of articles during the fifties by Fried (3), Sager (4), Papanek (5) and Lipschutz (6) dealing with the general subject of combined psychotherapy. The stress was on how the two approaches can be afforded equal importance in an overall treatment strategy or, in Wilder’s (7) case, how he utilized the group sessions to facilitate his primary reliance on dyadic psychoanalysis. The most recent comprehensive review of the entire subject of combined therapy by Bieber (8) was published in 1971.

There were many publications which depicted the use of combined therapy for patients with specific diagnostic categories. These range from an early paper by Baruch and Miller on the treatment of allergic conditions (9), through the use of combined therapy in inpatient settings by such writers as Klapman (10) and

Hill and Armitage (11), to a number of articles on the advantage of such treatment for oral characters by Jackson and Grotjahn (12), by Rosenbaum (13), and Tabachnick (14). Wolberg (15) discussed the use of combined therapy for borderline patients, while Glatzer (16) and Durkin (17), among many others, emphasized the special value of such an approach for narcissistic and other preoedipal character disorder. Some authors, among them Graham (18) and Shecter (19), employed combined therapy successfully with psychoneurotic patients.

As might be expected, the technical questions pertaining to the differential uses of individual and group sessions raised by Sager (20) and Spontitz (21), as well as to transference and resistance in these concurrently used modalities, evoked most interest and controversy in the literature. Thus, Stein (22) subjected the broader issue of transference in combined therapy to special scrutiny, while Beukenkamp (23) depicted the ways in which this approach could facilitate the resolution of transference problems. Berger (24), among others, paid particular attention to the subject of resistance.

Other technical issues such as the handling of confidentiality, when and how to introduce the group medium, and countertransference in combined individual and group treatment were discussed by Aronson (25) and Sager (26). Some authors such as Ormont (27) and Teicher (28) reviewed the relative advantages of combined versus conjoint group psychotherapy.

As we mentioned earlier, some authorities in the group therapy field view combined group therapy with disfavor, advocating instead an exclusive emphasis on group therapy alone. Wolf and Schwartz (29) for example, asserted that individual therapy would interfere with the establishment and resolution of the transference neurosis characteristic of what they termed "Group Psychoanalysis." Whitaker and Lieberman (30), Foulkes and Anthony (31), and Ezriel (32) are also against the use of combined therapy, claiming that the group medium is markedly powerful in its own right and that individual interventions

would be counterproductive.

The Unique Potential of the Psychoanalytic Therapy Group

When a clinician decides to add group therapy to the individual treatment of his patients, he is likely to be influenced by certain assumptions regarding the special therapeutic ingredients inherent in the therapeutic group process. These have been spelled out in much detail in the voluminous group therapy literature and will accordingly be reviewed here in brief outline only:

1. The Group as a Real Social Experience

The co-presence of a number of people fosters multiple interpersonal relationships revealing to everyone's full view each individual's coping and defensive patterns. As a group member's characteristic ways of relating emerge and evoke reactions from others, the stage is thus set for nonverbal as well as verbal interventions by other group members as well as the therapist. This is especially advantageous for those patients who in their massive employment of denial, projection, silences and withdrawal are difficult to engage in the one-to-one setting.

2. Multiple Transferences

In addition to the above-noted largely conscious interpersonal relationships, the unconscious group level is characterized by transference manifestations to other members and to the therapist, as well as to the group as an entity. These transferences frequently assume the representations of siblings, of parental figures, and of the family as a whole. The shifting character of these "neurotic" transferences—coupled with the emergence of more primitive, defensive transference manifestations such as "splitting," identifications and part-object relationships—allow for significant diagnostic observations and for appropriate therapeutic interventions both in the group and in the individual

sessions.

In this connection, the group psychotherapy literature is replete with discussions of the regressive perceptions and relationships which characterize the unconscious levels of group processes. These primitive emotional themes are believed by some writers such as Bion (33) to be of even greater "depth" than those elicited in the dyadic psychoanalytic setting. Such fleeting group manifestations pertaining to the reactivation of early relationship patterns and especially of primitive perceptions of the therapist, of the other members and of the group entity can be subjected to a more planned and controlled scrutiny in the context of combined therapy. Breen (34) provided a poignant illustration of some of the differences in the unconscious object relationship themes evoked by the group therapy and individual analytic settings, respectively.

3. Opportunity for Reality Testing

In contrast to the relatively unstructured dyadic setting which tends to promote only a regressive climate, the group, with its accompanying reality component of an open circle and the co-presence of a number of people, facilitates the testing of reality. Imagined fears, hurts and retaliations, as well as transference distortions, are thus subject to easier exploration and correction.

4. Support of Peers

While ego support offered in the context of individual psychotherapy is likely to reinforce dependency on the therapist, this is more readily avoided in the supportive climate of the group. Here, the frequently disheartened and demoralized patient is soon helped to realize that he is not alone nor necessarily the worst off. Furthermore, vivid examples of change for the better on the part of others promote hope for one's own improvement. The group's code of acceptance and of honesty, which is consciously fostered, tends to reduce irrational feelings of shame and guilt, to correct biases and cultural

misinformation. Being afforded the role of helper to others enhances each patient's self-esteem besides serving as a motivation to take personal risks on the road to newer behaviors.

Maximizing the Effects of Individual Therapy

The above-noted unique motivational factors for change and growth inherent in the group setting tend to enhance the effectiveness of the patient's simultaneous one-to-one treatment. In addition, other more experienced group members can serve as role models in the acceptance of irrational feelings and anxiety, as well as of the need for self-exploration, as a necessary ingredient of therapy. Furthermore, confrontations and interpretations by peers are often more readily accepted than those from the authority figure. The motivational reinforcement of the group's commitment to work toward therapeutic progress also helps to overcome resistances. While the earlier mentioned regressive group transactions are likely to facilitate the expression of deeply repressed ideations, the necessary lengthy, detailed and individualized working-through of such material is usually not possible in a group because the coexisting needs of so many others interfere with this process. It is here, as noted by Scheidlinger (35), where the individual sessions serve to complement the group situation, allowing for the repetitive and necessarily slow process of "working-through" to occur. The patient's observing ego is thus enabled to master the new insights at its own pace, with due regard to the inevitable resistances reinforced by early traumas.

Specific Indications for Combined Therapy

There is considerable agreement in the literature that combined therapy, while potentially useful with most ambulatory patients, is the treatment of choice for character disorders and borderline personalities. The integrated use of the two modalities lends itself especially well to working with primitive, pre-oedipal transferences and related rigid character defenses which, as noted by Kernberg (36), are frequently coupled with schizoid behavior and deep fears of intimacy.

(Some of these same problems are encountered in severe psychoneuroses.)

As we mentioned earlier, the group's aid in the evocation and resolution of complex transferences and resistances is likely to hasten the pace of individual treatment and its reconstructive nature. This is especially true under prevailing conditions of practice where financial limitations constrain many patients to a less intensive schedule of individual therapy than is clinically indicated. Under such circumstances, a single group session can often be combined with even a single individual session to marked advantage.

Following are some of the major therapeutic problems of patients with character pathology, including "borderline" conditions, which were found to be specially responsive to combined individual and group treatment.

1. Difficult Transferences

The varied complexities in the resolution of primitive transference themes encountered in pre-oedipal character problems in the dyadic treatment context are well known and do not require repetition. By introducing simultaneous group treatment, the patient's rigid narcissistic, paranoid, withdrawing or dependent transference patterns become subject to the group's scrutiny and confrontation. The therapist may at first need to use the individual sessions to support the patient in view of the group's undermining of his tenaciously defended perceptions. Subsequently, the inevitable negative transference reactions to other group members (siblings) are likely to be displaced onto the therapist, where they belong. At the same time, the positive transference ties to some of the group peers and the perception of the group entity in a positive maternal vein can serve as support on the painful road to the analysis of the patient's distorted angry perceptions of early objects in both the individual and group encounters. Individual sessions can be used flexibly— at times to offer ego support when the group's confrontations promote too much anxiety, at other times for analytic exploration and working through. Group meetings as well as

likely to serve varied functions at different stages of treatment. These include experiential frustrations or gratifications of transference wishes and direct verbal expressions and confrontations of transference feelings coupled with reality-testing and resolution.

2. Analysis of Rigid Character Defenses

We referred earlier to the unequalled value of the group setting for portraying interpersonal behavior patterns and defenses. In fact, group therapists have often noted with amazement how different their patients appear in the group when compared to their behavior in the dyadic sessions. Thus when the new group member's narcissistic defenses of grandiosity, aloofness and arrogance persist over a period of time, the other members are bound to confront and later undertake concerted efforts to demand relevant self-scrutiny and modification of the unacceptable conduct. Similarly, a cohesive therapy group imbued with a spirit of self-examination coupled with genuine emotional support when called for will not tolerate persistent patterns of projection, denial, withdrawal, withholding or intellectualization. The frequently painful sequelae of such transactions are likely to involve the therapist in both the group and individual sessions as supporter, confronter and interpreter, as the situation may demand.

Clinical reports are unanimous about the special value of a group setting as a way station for patients to work through problems of relating to members of the opposite sex or of schizoid withdrawal. Somehow, these issues are better *lived out* in at least a microcosm of the real world—the group—rather than being merely talked about in the individual session.

The Differential Uses of Individual and Group Sessions

During combined therapy, group sessions tend to be generally used to elicit and resolve resistances and to promote the expression of the earlier- noted deep

affects and phantasies. The individual sessions can then serve as the calmer “laboratory” to analyze these therapeutic productions, especially of primitive transference perceptions, in greater detail and comprehensiveness. In either session, the stress may need occasionally to be placed on the provision of ego support. As part of the working through process, group meetings are more likely to offer opportunities for experimenting with new behaviors while the individual sessions would stress the integration of deeper intrapsychic themes.

Needless to say, all therapists do not necessarily operate in accordance with this scheme. The unique needs of different patients, the variability in the character of therapy groups, and the therapist-style may dictate different ways in which the two media are harmonized to enhance the task of therapy.

Technical Issues in the Initiation and Scheduling of Combined Therapy

It is almost universal practice among therapists employing combined therapy to initiate treatment with a period of individual psychoanalytic psychotherapy, and to add group therapy at a later point. A common view is that group therapy may be introduced once the patient has developed a strong working alliance with the therapist and after a transference has been clearly established and at least partially understood. If the patient is introduced to group therapy too soon, transference patterns may become confused or repressed and therapeutic progress halted. In fact, some patients may flee treatment altogether should they fail to be fully prepared for the group and feel that they are being “thrown to the wolves” or abandoned.

Similarly, patients in individual treatment should probably not be brought into a group until the acute problems that led to the treatment have been at least partially resolved and the patient’s self-esteem is sufficiently strong to withstand the inevitable stresses entailed in group belonging.

In practice, there is considerable variation in the timing of combined

therapy, ranging from a wait of only a few weeks at one extreme to a preceding stretch of several years of individual psychotherapy, at the other.

Although the pattern of commencing treatment with individual psychotherapy and later adding group therapy is the most common approach, there is no reason why the reverse procedure cannot be employed. Thus, some clinicians begin combined therapy with exclusive group psychotherapy, and only after a period of months or years do they add individual analytic sessions. This scheme may be best suited to patients with previous psychoanalytic experience, or to those who are extremely frightened of their transference reactions in the individual treatment setting.

As for the therapy groups in combined therapy, these may consist of a mixture of patients, including some in exclusive group therapy and others in combined or in conjoint therapy. While this might seem to create formidable problems of transference complexity and of rivalry reactions within the psychotherapy group, most workers have actually found such an approach quite workable. Given sufficient sensitivity and experience in the employment of combined therapy on the part of the therapist, the use of a flexible approach permits a truly rich variety of therapeutic transactions.

As can be expected, raising the issue of joining a group with a patient is likely to provoke a number of concerns. Most common are feelings of rejection, narcissistic injury, separation anxiety and sibling rivalry. These feelings invariably provide significant themes for the ongoing treatment program.

Combined treatment is usually initiated either by adding a group therapy session to the patient's pre-existing schedule of individual sessions or by substituting a group meeting for an individual session. The decision is made on clinical grounds, depending on the optimal intensity of individual psychotherapy sessions and the availability of time and financial resources. Naturally, the issues posed by the planning for combined therapy will differ in the two circumstances

and the therapist must be prepared to deal with the relevant therapeutic material which is bound to arise.

The most common pattern of combined therapy appears to be one group therapy session per week combined with one or two individual sessions. Fewer therapists employ a twice-weekly group therapy schedule.

Whether it is feasible to combine a more intensive individual psychoanalytic schedule of sessions with group therapy has been extensively debated. Some writers maintain that the deep regressive transference of a classical individual psychoanalysis is incompatible with concurrent group therapy, while others believe that a schedule of three, four, or even five times a week for individual psychoanalytic sessions, including the use of the couch, can go hand in hand with group therapy. These therapists report that patients exhibit a variety of transference reactions in both group and individual analytic sessions. Although the anonymity of the clinician is obviously not preserved, the essential nature of the analytic development and resolution of the transference is believed not to be disturbed.

The most prevalent point of view at this time among practitioners of combined therapy is that intensive, three to five times weekly individual psychoanalytic sessions may be combined with group therapy. While this probably alters the nature of the transference relationship within the individual analytic treatment, the total process of this type of combined therapy is nevertheless considered as being compatible with the overall reconstructive goals of the psychoanalytic treatment process.

Confidentiality in Combined Therapy

The use of concurrent individual and group psychoanalytic sessions offers the therapist a range of possibilities in exploiting therapeutic material which exceeds what is possible through the use of either therapeutic modality alone. To

restrict the use of themes which emerged in either modality to subsequent sessions within the same modality only would deprive combined therapy of some of its greatest potential. For example, individual sessions may be utilized to permit the patient to discuss the defensive or transference patterns of fellow group members. These discussions may be a source of considerable insight for the patient and often facilitate his deeper understanding of similar aspects of his own psychopathology. Similarly, with the patient's permission, material from individual sessions may be productively employed to further understanding of this topic within the group transactions.

Considerations of clinical judgment and personal tact, are of course critical in the flexible use of therapeutic data emanating from combined therapy.

Combined Therapy and Conjoint Therapy

As we noted at the outset, "conjoint therapy" refers to combined treatment in which group and individual therapy of a patient are conducted by two different therapists. It is similar to traditional, shared treatment in most respects, and offers most of the same advantages.

The main issue which distinguishes combined from conjoint therapy is the effect of such a divided treatment structure on the working alliance and on transference. Conjoint therapy fosters the development of multiple transferences and of transference-splitting even more than the use of combined group and individual therapy. Some clinicians have claimed that this allows for clearer delineation, and hence for easier resolution, of some patients' transference patterns. Many others believe that the use of two therapists unnecessarily confuses the picture and invites complicated countertransference issues, plus the conscious and unconscious manipulation of the treatment situation by the patient to such a degree as to inhibit the successful resolution of basic pathology. At this time, it is probably fair to say that both treatment approaches appear to be effective, that their uses are similar, and that a clear preference for one or the

other is up to the therapist. However, the fact that conjoint therapy is used with much lesser frequency suggests some doubt among most clinicians regarding its efficacy in deeper, reconstructive psychotherapy. Further experimentation will reveal the specific ways in which combined and conjoint therapy, respectively, have their proper place in the therapeutic armamentarium according to the varying needs of different patients, psychopathologies and treatment situations.

Contraindications to Combined Therapy

There was a time when both group therapists and individual psychotherapists were wary of combined therapy. Individual therapists felt that the addition of group therapy to dyadic treatment would dilute it to the point where the attainment of analytic goals would be made more difficult, if not impossible.

As for clinicians who employ group therapy as the treatment of choice for most patients, they feared that the addition of individual sessions would drain off energy and material from the group.

It is our belief that to date neither side in this dialogue has been proven correct. We think that individual psychoanalytic treatment can essentially proceed with the attainment of its goals when group therapy sessions are added to the treatment regimen, and that, if anything, the work of character reconstruction may occur with greater alacrity and depth. Similarly, psychoanalytic group therapy is most often enhanced by the addition of individual sessions as patients are provided with the opportunity to work through issues in greater genetic and intrapsychic depth. The only two major clinical contraindications for combined therapy appear to be:

A) *Classical psychoneuroses*, which probably are still best treated with the technique of intensive individual psychoanalysis. For these patients, the addition of group therapy is probably unnecessary, since the latter's virtue is to facilitate

the resolution of the character problems and severe transference patterns which are not characteristic of the neuroses.

B) *Some borderline, psychotic and masochistic patients*, whose ego structure is such that they respond to the addition of group therapy with enhanced anxiety, regressed behavior or depression when exposed to the group's psychological forces of regression and contagion.

Clinical Examples

Case #1

Joe is a 32-year-old, public utility repairman from a poor working-class background. He spends his free time as part of a group of motorcycle riders who use a variety of non-addictive drugs. He is bright, upwardly mobile and committed to psychotherapy. His childhood was characterized by a severely dominating mother and the almost total absence of a father. He is overweight, fierce-looking, and filled with rage toward women, coupled with a strong desire to overcome it. He was married for five years to a woman whom he described as in many ways a carbon copy of his mother. He said that he did not love her, but nevertheless could not get himself to leave her and his five-year-old daughter.

Joe began once-weekly individual psychotherapy and a year later was invited to join a psychoanalytic therapy group led by the same male therapist. At first, the therapeutic work in individual sessions was largely supportive, aiming to help Joe deal more competently with his wife and child as well as with a variety of work-related practical conflicts. Joe related to the therapist in a friendly and submissive fashion.

In the group, Joe was initially withdrawn and silent, and was often depressed. His occasional talk consisted of sarcastic comments to the women members and deferentially friendly remarks to the males. He usually came dressed in his torn, greasy work clothes.

Over a period of two years, the other group members, at first gently then more firmly, confronted Joe with his tendency to withdraw into depressions instead of dealing with his problems. The defensive aspects of his "Macho" denial of dependency, of his dress, appearance and aggressiveness, were repeatedly emphasized.

In time, several significant changes were noted. In the group, Joe began to talk spontaneously during every session, emerging also as being concerned and involved with all group members. He could now acknowledge pain, inadequacy, and vulnerability in front of the others, including the women. In fact, he began to use the group to practice new ways of relating to women as equals whom he might care about. In addition, there were the beginnings of a kind of transference rage toward women, as well as, for the first time, towards his male group therapist.

At this point, the nature of Joe's individual therapy sessions gradually also underwent a change. Dreams began to appear and the sessions became less reality-oriented and supportive and more concerned with genetic and intrapsychic material. The heart of this work settled for a time on homosexual fears and wishes involving male friends, Joe's father, and the therapist.

After three years of combined therapy, Joe was enabled to separate from his wife, to lose a significant amount of weight, to alter his style of dress, reduce his involvement with motorcycles and drugs, and begin to date women for the first time in his adult life.

This case illustrates the following points concerning combined therapy: 1) The value of the group to reveal and resolve character defenses; 2) the use of the group to explore and begin to resolve patterns of transference rage; 3) the group's availability as a testing-ground for more adaptive behavior during the working-through process; 4) the opportunity to focus in the individual sessions on genuine reconstructive psychotherapy.

Case #2

Rose is a 28-year-old nurse who is married and has a nine-month-old son. Rose's mother is schizophrenic; one of her psychotic episodes followed Rose's birth. Her father beat the patient when she was young. Rose was in individual psychoanalytically-oriented psychotherapy for five years with a female therapist whom she described as "very supportive and maternal." She felt that she had benefited greatly from this period of treatment, but she and her therapist believed that a span of analytic group therapy accompanying the individual work would be helpful to work on issues related to her anger and need for more self-assertion.

Rose entered a therapy group led by a male therapist. At first, she was quiet and shy. She rarely spoke, even when she appeared to be obviously upset. The group therapist suggested that she experienced the entire group as her schizophrenic mother and that she felt that if she asserted herself by asking for help, the group would not be emotionally available to her, just as her own mother had not been. Subsequently, with continued encouragement from the others, she began to verbalize her feelings, requests and needs to an ever greater extent.

Following this, the other members began to consider Rose's shyness, hesitancy, and soft voice as relating to difficulties with self-assertion and anger. Her timidity and marked friendliness were repeatedly interpreted as reaction-formations to underlying feelings of anger. Soon, Rose began to oppose others in the group, starting with the females but then going on to challenge also the male members and the therapist. She reported a concurrent increased ability to confront her husband when she felt he was treating her unfairly. Recently, she gave birth to a girl and went through the postpartum and infancy periods without significant symptomatology. She is now making plans to return to part-time work over the mild objections of her husband.

Needless to say, the two therapists communicated with each other on occasion, with Rose's knowledge.

This case illustrates the following: 1) The conjoint use of individual and group therapy sessions with differing therapists, in which the individual sessions served a mixed supportive-reconstructive function and the group sessions came to take on a primarily reconstructive quality; 2) The resolution of transference patterns in the group; 3) The use of group sessions to reveal and resolve character defenses; 4) The opportunity offered by the group to serve as an arena for the practice of new, adaptive patterns of behavior.

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