COMENTÁRIOS À CONFERÊNCIA DE DAVID ZIMERMAN:

"AS TRANSFORMAÇÕES NA MINHA FORMA PESSOAL DE PRATICAR A GRUPANÁLISE AO LONGO DE UMA EXPERIÊNCIA DE MAIS DE 40 ANOS"

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Mrs. Chairman, Dr. Zimerman, dear Colleagues

Thank you for this opportunity of discussing this impressive and profound valuable paper about aspects of technique and the practice of group analysis.

I have myself not half as long an experience and it is indeed interesting and brave to present in more details what it is exactly, we are doing and find useful in our daily work.

Reflections on our therapeutic practice are necessary as a living and continuous monitoring and securing of quality. Reflections of changes give us something additional. If we make unexpected or unusual changes of our practice, counter transference is always in play. When changes are made intentionally and prepared, we have usually been inspired from experiences, others or our own, sometimes from clinical vignettes, sometimes from more empirical research. When we talk about a span of 40 years, the transformation of practice will mirror broader, cultural and political changes in our professional society and in the society as a whole.

One can wonder what caused the transformations. The presenter seems to like experimenting. Was it a long-term trial-and-error experiment, which gradually made the change? Or has it been going on almost unrecognised, till it became a personal style to describe?

Let me first comment on some of the advices given by Dr. Zimerman:

I very much agree in general with your considerations about selection and gathering patients at the same psychopathological level.

For the patients with a more severe psychopathology though, I don't think we can expect to be guided by "motivation" as such; the important task for the therapist at the moment of the first interview is to "connect" to or if possible make a beginning alliance with the patient.

Instead of leaning on the counter transference, which I find a very unfaithful variable (I have tried to use this variable myself as a predictor variable both with personality disordered and schizophrenic patients, with discouraging results).

I will in stead suggest that the patient

1. Describes his experiences with groups in the past (in school, in sports, as a scout, in the military and so an) and
2. Fantasizes about what would happen in the group, if our "conversation" had been situated there. This gives a good opportunity to dismantle paranoid preconceptions about the other members and to reduce anxiety. For very discouraged patients, I sometimes say that the group is exactly for people, who cannot thrust and hope anymore.

I think there are very few exceptions as to who can be treated in groups. What the therapist has to do is to formulate the patient's problems and difficulties in relational terms. For borderline patients, who are the "black sheeps" in the Mental Health Services and who provide great difficulties for emergency services, group therapy in different variations seem to be a practicable and successful possibility. With these patients the most important task for the therapist is to prevent dropout; that is to be aware and to immediately repair ruptures of the alliance.

The usual components of the therapeutic alliance measured by current research rating scales are:

1. the patient's affective relationship to the therapist;
2. the patient's capacity to work purposefully in therapy;
3. the therapist's empathic understanding and involvement; and
4. the patient-therapist agreement on the goals and tasks of therapy.

We have for about ten years believed that this was indeed the decisive factor. Now it appears that these constructs cannot fully conceive, what makes a good alliance and a good outcome. We must look deeper into the relationship. The current focus is on "mediators and moderators" of the therapeutic alliance and on interventions for creating and maintaining a therapeutic emotional climate, for example cohesion in group therapy. Also therapist relationship skills have been demonstrated valuable in several studies. The interest is especially on empathy, the "psychoanalytic mode of observation".

Although we like to imagine that our technique and we are the most important factor contributing to outcome, the research literature does not support this contention. On the contrary, outcome is determined to a great degree by the patient and outside events – not the therapist. On the basis of his revue of the extent literature, Lambert in 1992 concluded that as much as 40% of the improvement in psychotherapy clients was attributable to client variables and extra therapeutic influences. For instance the length of time that the disorder had persisted, the presence of an underlying personality disorder, and the nature, strength, and quality of social support especially the marital relationship, affected change.

Only 15% of the outcome was predicted by the technique.

When I red the paper – passage for passage – I realized that Dr. Zimerman's observations, technique and priorities, did not differ very much from my own group conducting.

You have not made explicit what theory lies behind, and there are only few references to proponents of the different schools. Your methods and technique is indeed eclectic, based. I guess – primarily on theories by Klein, Bion and Ezriel and on the American "Group Psychoanalysis".

But does it matter what kind of theories the group analyst has in his or her mind? What do we need these theories for? – Theories help to organize and give meaning to otherwise chaotic and incomprehensible situations, and provide guidelines for useful interventions. But the group analytic situation is so complex, that we never will reach the point where a theory fully will cover group events and provide exact instructions for action. Theories are models that we use as long as they are meaningful to understand what we experience. The American psychoanalyst Paul Ornstein suggested, that we are guided in

our interventions by theory in two different ways: In the moment to moment situation of therapy by a private, unarticulated theory amalgamated with our chosen public theory, and in the macroprocess (that is what the patient has to traverse in the analysis to achieve a cure), in which the interventions are more explicit guided from the perspective of our favoured public theory.

I have noticed that Dr. Zimerman in the presentation has named his methods with slightly different labels: "Group analysis", "Psychoanalytic group therapy", "Analytic supportive group psychotherapy" and "Analytic Group Therapy". It is – I think – not coincidental and my understanding is that it mirrors the continuous changing in understanding and practice of group therapy and changes in the culture and population of patients. In the beginning it seems to be students out of money, later perhaps patients in the mental health service and now maybe again young people, who pay for their therapy.

Dr. Zimerman mentions that patients may resist in a group, hidden in silence or detachment, without ever exposing themselves. And this is highly criticized by opponents of Group Analysis. I think this is a part of a common misunderstanding in America about the English group analysis, that you in these groups are afraid and left alone. I still remember – sitting at the IAGP Congress in Montreal in 1992 – how a female American colleague reacted with unbelief and felt sorry for me, that I have been trained in a Group Analytic group. The usual local exhibition of books by the way – held no literature at all about this "cold" and frustrating therapy method.

Group analysis differs from other group psychotherapies in the respect that it emphasizes more strongly the autonomy of the group. The group analyst does not prescribe the aims and the norms. The group has to develop these means by itself, although by the aid of the analyst.

Six years ago at an EGATIN conference in Norway the question was asked: One Group analysis or many? I think the answer was yes. There are a variety of psychoanalytic theories that guides different practices of group analysis.

The European group analytic theory – based on the writings by Foulkes and Bion – has through the last

10 years been criticized and revitalized by a second generation of theorists, like Morris Nitsun, Farhad Dalal and Sigmund Karterud.

The strength of the American way compared to the European, was a will to experiment and seeking new ways, in combination with American pragmatism: The most important is that the therapy works, not that it can be founded theoretically. The way of group therapy was ego-psychologic psychoanalysis in the group (represented by Slavson and Alexander Wolf). Today the most prominent form of group psychotherapy is psychodynamic group psychotherapy. It has integrated many of Foulkes' views about psychotherapy of the individual by the group, although the typical American style is more directive and individual oriented, than the group analytic.

Transference and other misconceptions are multiple in groups. The value of fellow members pointing out these misconceptions is well known. Therapy by the group is very useful.

Group analysis is however not a question of interpretations. Foulkes had an unclear distinction between interpretations and other interventions. Interpretation – he said – is a

verbal communication from the therapist to the group or to certain members, with the intension to bring into their attention connexions, which he think is unconscious for them, but can be conscious with verbal help from his side.

Foulkes contrasts analysis and interpretations. Analysing – he says – is a form of investigation which can help a patient to understand something about himself. If he cannot make it alone, the focus must be to what kind of anxiety and feelings impedes him, in short – to his unconscious resistance and defence.

This is a more active task for the therapist than interpretation.

Finally I noticed that the group presented had (and I quote) already been in treatment for many years, with practically the same composition. That made me wonder if Brazilian Group analysis is more longterm or intensive than English or Danish, or if groups in private practice are more long term than public sector groups, where patients are more disturbed.

The therapist as a real person is he different in Portugal or Brazil, compared to the therapist in Scandinavia? Would we not expect the interaction between the therapist and the group after all to be influenced by the general culture of family and society in the country, for example concerning authority and dependency?

EFPP addresses psychoanalytic psychotherapy as performed in the public sector.

In general the public sector in Europe asks for treatment of patients more than neurotically disturbed, and often within a short time limit, as opposite to private practice, where patients can pay and stay as long as they do that.

The public sector patient population is a great challenge to group analysis, which can be moderated and modified in various ways – primarily by adding supportive elements (and then be labelled Group analytic psychotherapy.). There are reports that group analytic psychotherapy can be implemented with success in the psychiatric treatment of patients with severe psychopathology.

Thirteen good reasons to choose group therapy for individual therapy have been listed in the paper. The one – maybe most influential – has not, namely the obvious economic advantage of treating seven patients at the same time.

In spite of all these advantages the reputation of group therapy in general is still not good. One reason is the hesitant, non-judgemental, "analytic attitude" of the (group) analysts: We don't advertise our method!

I don't know what qualified the 60's to be the golden era of analytic group "therapy"; in general I believe the golden era has just begun.