
Experience in group analytic psychotherapy

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The Royal College of Psychiatrists classifies group psychotherapy as required experience for psychotherapy training as part of general psychiatric training (Grant *et al.*, 1993). This is defined as group experience in in-patient and/or out-patient settings, with an experienced co-therapist and/or supervision. Previous surveys estimate that the percentage of trainees gaining such experience ranges from only 9% (Arnott *et al.*, 1993) to 58% (Hwang & Drummond, 1996). The limited duration of psychiatric training does not allow experience in all types of psychotherapy and trainees must therefore be selective in respect to their own training, depending on what is available.

Training in group psychotherapy may be more valuable to trainees than other psychotherapy experience in considering the nature of modern psychiatric practice. I describe my own experience of group analytic therapy as co-facilitator of an out-patient group for psychiatric patients.

While working as a registrar in general psychiatry, I was invited to co-facilitate the group by the recently appointed consultant psychotherapist. Recognising a rare and unusual training opportunity, I accepted, although not without some apprehension. The patients had already been assessed but I was present at a 'pre-group' meeting attended by some of the patients. The presentations were typical of patients referred for long-term psychotherapy, with diagnoses of chronic affective, neurotic and personality disorders. There were 10 patients in total, three men and seven women. The group, which was closed in design, ran weekly for 16 months with sessions lasting 75 minutes. My supervision and teaching consisted of a weekly meeting with the consultant.

Clinical experience

It took some time to adjust to the unfamiliar process of group therapy. My perception of analytic psychotherapy had been one of a highly intellectual discipline with an esoteric language. I soon came to realise this was not the case and that reflective analysis focused on the patterns of

interaction in the group and each member's contribution to it.

I can still vividly recall the opening silence of the first session and the anticipatory anxiety in the room; the power of the group was striking both in its creative and destructive potential. It was initially inhibiting having a consultant as co-therapist as I feared my contributions would be rigorously scrutinised. My participation was tentative at first but in time I was able to make interpretations to the group. It was important to learn that interpretations of the process were easier to make having reflected on one's own feelings within the context of the group.

Therapeutic factors at work in the group soon emerged. Universality, altruism, vicarious and interpersonal learning were particularly important. It is interesting for a doctor to view a group itself as a method of treatment, a therapeutic entity, empowering patients to help themselves. The most striking observation was the process of individuals learning how to communicate with one another on a meaningful level. Several patients disclosed childhood sexual abuse and others shared their dreams and personal writings. Practical problem-solving was also common, particularly in times of crisis. An insight into the coping mechanisms patients use for chronic and distressing symptoms is invaluable for psychiatrists.

Powerful defence mechanisms frequently came into operation to act as a barrier to interpersonal communication. It was commonplace for psychodynamic interpretations of transference to be quickly dismissed by both individuals and the group. Critical attacks on us were frequent and usually directed at the consultant. It was difficult to learn how to use these criticisms constructively in the group analysis.

Three patients left the group within the first six months but the remainder continued to work cohesively. The sense of belonging was important to all members. I too shared this sense of belonging in being part of a process of change. It was difficult changing 'roles' and moving seamlessly from junior doctor to co-therapist and vice versa. The group presented a regular (if unpredictable) event in my week. Over its time

span I rotated through three registrar posts and passed the MRCPsych Part 2 examination; stable factors such as the group certainly contributed to my success at membership. The process of ending was predictably difficult for the group with issues of loss and abandonment. My own feelings were a mixture of relief and sadness; relationships with group members had a different quality to that of the conventional doctor-patient relationship. The experience taught me the value of continuing psychotherapy as an integral part of my psychiatric training.

Comments

Participation in out-patient group analytic therapy is a very useful component of psychiatric training. It represents a significant time commitment in terms of sessions, writing up notes and supervision (approximately four hours/week). Supervision arrangements must address both the trainees' needs in terms of individual training and supervision but also the external supervision of the co-therapists (the latter was unfortunately unavailable). It is not practical for trainees to be involved in the initial patient assessment and therefore a preliminary meeting of the group is an important first contact point. There remains a disparity between consultant and trainee in terms of expertise but also in the patient's view of the consultant's knowledge (as assessor) of their intimate history and difficulties. This is important to remember when analysing attacks on the co-therapists in terms of defences such as splitting and projective identification.

Group analytic psychotherapy is a demanding exercise which forces the trainee to reflect on their own role within all groups (professional, social and family) in which they interact. An awareness of group processes is essential to psychiatry and this is best gained through direct experience in a group. As with all long-term psychotherapies, contact with patients over a longer time period than the typical six-month training attachment is useful preparation for consultancy; often the first time psychiatrists embark on long-term relationships with patients.

Psychiatric trainees gain more experience in individual psychotherapy (analytic or cognitive) than other types of psychotherapies. Individual psychotherapy is clearly essential experience for trainees developing skills in the doctor-patient relationship and historically there has been a preference for this training. The traditional view of the relatively independent clinician has given way to multi-disciplinary working and involvement in management. These changes have altered the role of the psychiatrist who has to

operate more flexibly in group systems as leader, supervisor or facilitator. Experience in group analytic psychotherapy can provide a better understanding of these roles when considering the dynamics operating in teams. An example is the phenomenon of the anti-group (Nitsun, 1991), which describes the attitude of fear or dislike of groups which can be enacted in destructive ways. Multi-disciplinary teams operate under difficult circumstances in the National Health Service but it is often group dynamics that determine their effectiveness. Increasing anxieties (demands from managers or government) may not be able to be contained within the group and result in attacks on the group's existence. Fragmentation of disciplines (by splitting) or scapegoating (multiple projections from group members) are common results. These defences clearly undermine the joint therapeutic process and psychiatrists have a role in enabling individual members to understand them. Psychiatrists also need to be aware that feelings of despair or helplessness in themselves can be a manifestation of the anti-group; such insights may prevent burn-out.

Experience of groups that are functioning well is equally important for trainees. The group structure must be sufficiently containing to promote trust, genuine exchange and the exploration of shared anxieties and ideas. This ensures members take responsibility for each other, increases their effectiveness and improves morale. The need for understanding of the effects of institutional dynamics on our profession has never been greater; promoting a strong group identity for psychiatrists is important for the future.

Group psychotherapy, in its attention to the principles of general systems theory, may therefore offer advantages over individual psychotherapy in respect of psychiatric training and better equip the trainee to survive the stresses of current psychiatric practice. Recent research found the majority of psychiatric trainees rate psychotherapy as highly relevant to their overall training (Byrne & Meagher, 1997). Unfortunately, the ideal scenario of experience in all types of psychotherapy is not possible due to time constraints. Current deficits in training relate more to the supply of opportunities and supervision rather than low demand from trainees. Hopefully this will increase in all modalities of psychotherapy and I would particularly recommend the value of experience in group analytic therapy.

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