Group psychotherapy: the practice and the formation of homogeneous short term groups

José Guimon

Abstract
In fact psychiatric diagnoses, (not geriatric), are grouped, using the DSM-IV nomenclature, into ten psychiatric problems: general anxiety disorders, social phobia, obsessive-compulsive disorders, agoraphobia, panic attacks (with or without agoraphobia), disorders from post-trauma stress, schizophrenia, abuse and dependence on drugs and alcohol.
In a recent work we proposed to group the first six problems into the "anxiety disorders", and to add "eating disorders", "personality disorders" and "psycho-geriatric disorders". Thus we have seven groups of problems that we will look at from another perspective. Group psychotherapy until recently was a treatment that took time, but now interest is increasing for shorter group psychotherapy.

Key words: psychiatric diagnosis, group psychotherapy, homogeneous short term groups, indications, technical problems

The length of the treatment is perhaps the factor that influences most the other variables of the group activities. In fact if we have to establish a typology, long term and short term groups are situated at the opposite ends. At the long term end, groups with a psychoanalytic approach are situated. The group leader has an analytic attitude, seldom intervening, remaining rather passive, trying to reveal him/herself as little as possible. These types of groups are generally heterogeneous concerning the diagnosis, and semi-open. The group phenomena have great importance during the psychotherapy and go to make up the therapeutic components and the factors of resistance, and are most often than not interpreted. Reference is often made to childhood episodes of the patients and to the phenomena produced in the "here and now" of the session. Dreams are interpreted, in particular those that refer to the group.
At the other end of the typology, we have the short term group. Groups that are typical of this type are groups with a psycho-pedagogic approach. The group leader participates in a very active manner, giving advice and making him/herself known to the group. The groups are closed. The group processes even if they are important for a good functioning are not taken into consideration all that much, nor are they interpreted. The transference is not a decisive element. The importance of branching outside the group into daily life is underlined, to utilise what has been grasped during the course of the sessions. Other conceptual models of psychiatry (dynamic, interpersonal, cognitive, behavioural, educational), are situated in the intermediate areas of the typology.

Long term groups therefore are generally heterogeneous, this enables them to face a wide range of different styles and characters, defensive manoeuvres, different types of problems and diagnostic situations. On the other hand group therapy for short terms, is usually organised in specific environments that determine the objectives and the selection of the patients, thus making these groups homogeneous. The members tend to centre on a problem in common, thus facilitating the sharing of the experience and consequently reducing the conflict between the participants, ensuring a stronger mutual support.

2. The psychoterapy of short term groups

Short psychotherapy has been defined as being focalised and limited in its objectives and time. The therapist uses criterions for specific selection, tends to establish an initial agreement in detail, he/she appears active in developing a therapeutic alliance, has an optimistic attitude, and periodically evaluates the results.

The therapist usually agrees upon twenty-five sessions which is the maximum for dynamic, short therapies, but in reality the margin varies between one (Bloom 1992), and forty sessions. Today there is a tendency say that the positive results are in relation to the duration, "time-effectiveness" or in relation to costs, "cost-effectiveness" rather than brevity.

A recent survey from the United States demonstrates that 84% of all consultant psychiatrists declare to practice some kind of short therapy. Therapists with a psychodynamic approach had a preference for therapies with a long or moderate duration, and they spent less hours in short term therapies compared to those who had other theoretic orientations. They were responsible for a quarter of all the short term therapies in the U.S.A., although feeling less able to utilise them and finding them less efficacious than their other colleagues. In actual fact they were less involved in these techniques, even if it is clear that short therapies require a specialised involvement because of their specific methodology (Bauer et al. 1987; Levenson 1944). These reflections bring to the conclusion that a wide number of psychodynamic therapists are in conflict, carrying out short term work in which they scarcely believe, bringing them to a point of demoralisation ("burnt-out syndrome").

In reality, short therapies are not well accepted by therapists who are used to work in depth and for long periods, their perfectionist attitude makes them think, "the longer the better", hoping to actuate profound changes in their patients' personalities. According to some authors, these therapists habitually feel the effects of the conflicts relating to separation and loss and the responsibility towards new patients; they want patients to be in need of them; also fear of economic problems makes them feel insecure in the face of new techniques.

So, practicing psychotherapy for short terms means that the therapist has to accept the fact that complete recovery is not possible, that life too can bring about changes, that some changes may come about after the cure, that the cure may be useful, but it may be also harmful, and sometimes it is better to be alive in the world rather than in therapy (Bolter et al. 1990)

3. The clinical expansion of homogeneous short term groups

As far as Europe is concerned, a study we carried out in Switzerland allowed us to gain an idea of the characteristics of homogeneous short term groups compared to heterogeneous groups regarding the diagnosis. As far as length is concerned, the long-term groups (40%) are more often conducted according to a single theoretical model (73.1/53.2%)(***) and the psychodynamic orientation is mentioned frequently (65.1/35.4%)(***). These groups often include patients with different diagnoses (72.6/52.5%)(**)but in particular diagnoses of personality disorders (45.7/28.1%)(***) anxiety disorders (41.1/31.2%)(*) and psychoses (18.3/10.6%)(*). They are particularly represented in private practices (36.8/23.7)(**) and in day hospitals (8.0/2.7)(*).

As for diagnosis, 38.6% of the groups included patients with a single diagnosis. Those which included psychotic patients (14,3%) were more often long term (53.3/37.8%)(*), conducted in a psychiatric hospital (27.5/16.1%)(*) and with a psychodynamic orientation (60.9/44.1%)(*). Those involving patients suffering from depression (38%) were formed of adults (86.7/75.2%)(**) or older people (11.6/5.9%)(*) and were all conducted along essentially psychodynamic lines (54.3/41.7%)(**). When patients had anxiety disorders (35.1%), the groups were mainly long term (46.8/36.3%)(*) and often took place in private practices (39.4/22.6%)(***) with a psychodynamic approach (55.3/41.7%)(**). Patients with personality disorders (35%) were generally treated in long term groups (51.9/33.5%)(***) and usually had a rather psychodynamic orientation (61.0/38.5%)((***). Eating disorders (22.5%) in adult groups (87.6/77.3%)(*) or adolescent groups, (28.6/15.0%)(**) and drug abuse (22.3%) in groups mainly comprised of adults (97.1/74.7%)(***) or adolescents, (28.6/15.0%)(**) were conducted in psychiatric hospitals (31.5%/13.8%)(***) and tended towards a cognitive-behavioural (44.4/33.0%)(*) or humanitarian model (23.1/10.6%)(**). Finally, somatic illnesses were treated in short term groups (88.9/58.2%)(**) often with a cognitive-behavioural orientation (67.9/33.6%)(***).

4. **Indications for homogeneous groups based on the diagnosis**

Classical authors in their writings (Yalom), maintain that schizoid personalities, chaotic egos, emotional illiterates, people suffering from depression, people suffering from severe hysteria, and psychopaths, should be excluded from group analytic psychotherapy. Some authors believe that homosexuality and psychosomatic disorders are contraindicated, while others have treated these disorders with success using this technique. Also patients who are demented, paranoid, narcissistic, hypochondriac, or have suicide tendencies, drug addicts or alcoholics, serious psychotics and sociopaths are not ideal candidates to participate to group therapy. In spite of this, specific homogeneous groups have been formed for psychotics, people with mental deficiencies, chronically-ill people, alcoholics and drug addicts. In fact

these type of patients take part in group treatment, that take place preferably in psychiatric hospital centres, or elsewhere but with modified procedures. But at a certain point in their development, these patients can benefit from group treatment exclusively in day centres, in homogeneous groups.
Many studies have recently described group treatment for people with specific physical illnesses, for instance, genital herpes (Brob, 1986), cancer (Rawzy et al. 1990; Fawzy et al. 1990), (Rorester et al. 1993), HIV infection (Kelly et al. 1993), or with social problems, for example, abuse in the couple (Palmer 1992), and incest (Alexander coll. 1989). Also studies have taken place on homogeneous groups for people with psychiatric problems, like psychosis, mourning (Piper, 1992), anxiety, depression (Bubnam et al.1988) agoraphobia (Ebann et al.1991), or avoiding personalities (Alben, 1989).
The length of treatment of these types of groups varies between two days and fifteen weeks with the number of sessions ranging between two and twenty-four. The frequency is generally once or twice a week (usually once), and they last between eighty minutes and a whole day, (ninety minutes is the usual length).
Budman and Gurman (Budman 1988 #906), consider that even groups of a maximum of seventy sessions are brief. If the objective is the treatment of people with serious disorders dealing with interpersonal relations, it is necessary that there is a set time limit and that the group has a defined focus treated in the shortest time possible. Even if it is difficult to consider a group to be brief if it lasts more than a year, this length of time is much shorter than traditional groups with patients with interpersonal problems, for example borderline personality disorders. Even if the difference between a long and a short therapy is usually measured in time, there is another difference that is fundamental, and that is the nature of the therapeutic aim. The aims of a short therapy must be clear and limited because otherwise success is not guaranteed. The results are satisfactory (McCallun & Peter 1990), when cohesion rapidly comes about, the focus point is clear, the temporal limits become conscious, the therapist is active, the focus point is established on the relationships and the behaviour is present. In fact the major part of groups utilise what Dies calls,(Dies 1992 #621) an approach that is orientated towards action, utilizing the cognitive-behavioural technique.

5. Technical problems involved

In spite of their effectiveness, short term groups are not used a lot in managed-care programmes. Different obstacles make their practice difficult. Namely, the way the therapist works, the acceptance of the patient and the prevailing logistics for constituting short term groups in a managed-care context.
From a technical standpoint, the starting up and the continuation of these groups is much more difficult to achieve compared to long term groups, mainly because when a patient leaves one of these groups, he /she has to be replaced with a patient with analogous problems. Therefore these short term groups must necessarily be organised

in institutions that have a lot of patients and where the group has a foremost place in the programme of treatment.
French's (1954) ideas on short dynamic psychotherapy were adapted by Ezriel (1950)(ib., Mackenzie 1990) in group therapy, but it was only from the beginning of the 1980's that the works published were examined and started to be organised. The data of these reports refer to the experiences in those units where the psychiatric admissions were brief (Maxmen 1984, Yalom 1983, Rafaelsen 1989, Giumon 1989,) in a group "meeting" situation (Lieberman 1972 #346) and in specific programmes, for example those that provided advice and help to patients who had suffered heart attacks or bulimic patients (McCallum and Piper 1988). Ezriel (1950) following Bion's steps, described the emerging tensions in the group resulting from the repressed "avoided relationships", that determine terror or "calamitous relationship" to be resolved by "required relationships". He also adapted French's concept of "nuclear conflict" to the group situation.
Many attempts have been made to shorten the length of analytic therapies in day centre work. MacKenzie (1994) maintains that the traditional technique of psychodynamic and interpersonal groups can be modified for a limited use in time without forgoing the basic values and resulting in a satisfactory success. The doctors' task in conforming to a budget is not an easy one. We must always be prepared to inform the local health unit that in order to obtain satisfactory results for our patients it is necessary that specific directives are respected. Following this line of thought, McCallum et al. (McCallum 1993 #884) conceived a short term group therapy with a psychoanalytic orientation. Tuttman (1997), President of A.G.P.A. reminds us that doctors with a psychodynamic orientation must take into account that the efficacy of group treatment is in direct relation to the quality and solidity of the "therapeutic alliance".

6. Teaching the short term, homogeneous group

About twenty years ago the formation of group therapists required the participation of the candidates to groups that were preferably heterogeneous (if possible together with patients) and generally with a psychoanalytic orientation. Even if this continues to be the most preferable manner, the reality in public health services today require a large number of specialists with techniques for therapies with limited duration and necessitating little resources.
In 1982 we offered to give specialists of the Public Psychiatric Service in the Basque Countries the opportunity to examine their interpersonal relationships, by proposing a general course on work in the group (Guimon 1982 #1155). We contacted the Institute of Group Analysis in London whose programme developed along two lines. First an introduction to the work in groups that took place every Friday afternoon in two sessions lasting ninety minutes each for thirty two weeks, and second, a group of sequential lectures, in which each lecture gave the opportunity to follow an eighteen hour experience during the last three days of the week. This took place between four and eight times a year. After which, we repeated the course twice a year at Bilbao,

with a twice weekly frequency. This was followed by a programme of complete formation lasting three years.
Some activities, identical to the above-mentioned took place at Barcelona. The training programme for becoming a "Specialist in Group Activities" comprises of six intensive lectures, while a "Master in Group-analytic Psychotherapy" comprises of eight intensive lectures for two years, they take place from Friday to Sunday. More than one thousand four hundred specialists took part to this formation in Spain.
In 1994, with the objective of establishing a "therapeutic place" with an orientation towards a "therapeutic community" in the consultancy unit of the Psychiatric Service in Geneva, a large number of groups now take place in the various units coordinated by specialists of mental health with different theoretical backgrounds. We staged a "lump" programme for the interdisciplinary teaching, (psychiatrists, nurses and psycho-sociologists). Our aim was to provide an experience of personal participation, not just to a group, but to a "didactic community" giving them the opportunity to experience a real therapeutic community. The course comprised of four lectures of four days, including small groups, large groups, time for theory and supervision of the group work done by the participants.
The three hundred specialists who participated in Geneva and in other districts, work principally in the community psychiatry services, some work privately and others in social assistance services. The major part participated for one year to the course, while only a few followed on for another two or three years.
These experiences in Bilbao, Barcelona and Geneva (Guimon 1985 #369) favoured integration between the specialists of the various work teams of the Mental Health, providing them with a place for meeting and a common theoretical view that could be referred to, and was very useful to everybody. The lectures dealing with the supervision gave an overall view of the institution and the therapeutic work teams. We agree with Frankel's (Frankel1993 #821) experience which describes a group of formation of mental health workers, that in their turn conduct groups of patients. He studied the effects of the projective identification on different "containing" environments without overlooking the theoretical conceptions on object relationships. The possibility of individuating the complex game of the mutual identifications between the leader and the participants helps to understand the same phenomena in the mental health units.
Our experiences with short term homogeneous groups that we have been practicing for some years now, have been selected for a book to be published soon (Masson, Paris). This book is not intended to be a "manual" describing in detail the procedures, nor is it similar to those elaborated for different types of individual psychotherapies: cognitive-behavioural (Beck 1979 #1054), or interpersonal (Klermann 1984 #1055), psychodynamic (Winston 1994 #1056), or group (Piper 1992 #1057) psychotherapies. But rather, is a guide whose aim is to integrate the different movements that have developed, in particular in the second half of the twentieth century, starting from the initial psychoanalytic experiences leading up to today's

focal groups, without neglecting the "meeting groups" in the United States in the 'seventies.

Footnote. The first figure in parentheses indicates the percentage of the group in question for each typical trait whereas the second figure indicates the percentage of all the groups which do not present this modality. The x2 test has been used. The significance is expressed as follows: (*) p < . 05 / (**) p < .01 / (***) p < . 001.

José Guimon, Professor of Psychiatry. University of País Vasco (UPV/EHU)
Mail: jose.guimon@ehu.uv