DISCUSSION: GROUP THERAPY FROM THE PERSPECTIVE OF A LARGE FAMILY AGENCY *

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ANY discussion as to the feasibility of group treatment must consider not only the administrative problems involved in organizing such a program in an agency but also should consider the problems of technique as they may involve initial selection for the group and keeping the members involved in therapeutic relationships.

Mr. Brownstein has carefully reviewed the literature describing group treatment in family service agencies and has summarized the major organizational steps necessary in order to put group therapy into effect, whether in small, intermediate or large family agencies. His description of his agency's experiences in setting up therapy groups in his community reveals thoughtful consideration of the many problems involved and a professional approach to solving them. It is notable that the Paterson agency felt it desirable to use the services of a group therapy consultant qualified to train group therapists and to help the staff evaluate the program when problems arose.

From our experience in the Detroit area this is a necessary and wise approach. The eight family agencies in the Metropolitan Detroit area, with the support of United Community services, hired a group therapy consultant who comes in regularly from New York to meet, in a seminar, with the group therapists, supervisors, casework directors, and executives, to discuss case material, techniques, and any special administrative and treatment problems that arise. Frankly, I doubt whether group therapy would have been successfully launched in Detroit without such consultation. For, although the agencies may have the advantages of more caseworkers or supervisors, as well as clients, to draw upon in initially forming groups, we should not forget that the process of beginning is difficult for the worker or the client, whether he comes from a small or large agency or community.

Most staff members do not have any previous experience in group therapy and must start their first groups with a good deal of apprehension as well as courage, and with all the uncertainties that flesh is heir to whenever one begins a new venture. Sharing the knowledge of our experienced group therapy consultant, and receiving his emotional support, as well as that of other novitiates attending the group therapy seminars, has undoubtedly sustained many of the caseworkers during these months of trial and error.

Obviously, to the client in a large agency this is, usually, his first experience in group therapy and his trepida-

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tions and anxieties are similar to those experienced by the client in a smaller agency.

Yet there is a difference. There is more likelihood that the client will have an additional anxiety that is related to the smallness of the community. It is his concern at meeting, in the group, individuals whom he may know personally, even if casually or by name only. His concern is intimately related to his fear that the confidentiality of the material discussed in the group will not be respected by other group members.

This is a real concern and should not be considered solely as resistance to treatment. But let me state clearly that it is a problem that occurs in a large agency also, although less frequently. I recall that in the Battle Creek Child Guidance Clinic, covering a population of close to 150,000, we formed a group and found that several clients were distantly related, or their husbands worked for the same employers. In JFCS, Detroit, serving a population of approximately 80,000 Jews, we formed two groups of mothers. In both groups we have had the problem of group members knowing each other or being concerned about the prospect of having their confidential revelations discussed outside of the group.

In one group there were two cousins. At the time of selection for the group we did not know of their relationship. When the group was formed and this fact came out, it was handled by the group therapist. She used skill in attempting to have this problem discussed in the group and occasionally in individual interviews. But one of the cousins left the group and is now being seen by the therapist on an individual basis. Briefly, these clients had difficulties (a) in sharing certain material related to marital relationships, (b) in expressing negative reactions to each other, and (c) in discussing difficulties presented by the relationship.

There was a need, on the part of both individuals, to deny such difficulties, even when confronted by other group members, as well as by the group therapist, concerning their interesting patterns of attendance and absence that seemed related to their avoidance of each other in the group.

In another group we have two women whose husbands are in the same profession. Although the families do not know each other, one of the women has been having great difficulty in discussing many aspects of her family and marital situation. Her husband has been ill and suffering financial reverses, whereas the other man is financially successful. This material can often be handled in group discussions; the woman's disappointment in her husband, her problems of status related to financial success. To date, however, it has been difficult to have her discuss her feelings on these matters because of her concern that knowledge by others as to her husband's illness may affect his future employability. Although the worker has utilized complementary individual sessions to help this woman bring out her feelings to the group, the client has remained fearful and has not revealed this information in group sessions.

From these case illustrations it becomes quite clear that one cannot discuss the organizational problems of forming groups in small or large cities without also considering matters of technique. For example: Should the worker actively intervene and bring these problems to the table for discussion? Is it helping the client more to see her in separate, individual interviews, rather than having the clients face the issues and handle their feelings in the group? What family relationship material is sacrosanct and should not be discussed? Or should one more properly say that it

is all "grist for the mill," and should be brought into the group for discussion?

I will not attempt to answer these questions, for many of the answers depend on the individual circumstances in specific cases. It depends on the individual pathology, the problems being discussed in the group, and the level of group treatment attempted.

Equally important is the worker's conception as to what transference aspects can be handled and what should be avoided. To what extent does the worker try to be "supportive" and to avoid discussion of emotion-laden material? Are there counter-transference feelings involved? Is the worker identified with one of the relatives in the group, or with the family suffering from illness and financial reverses and is he thus, out of identification or protectiveness, avoiding any possibility of embarrassing these individuals in the group? Though no such feelings were involved in these specific cases, I make this point because we should be careful about making generalizations about administrative problems in group therapy without also considering the matter of technique and how this affects the administrative problems. With some workers, group therapy will never work, even if they are operating in agencies serving a population of 1,000,000. In other small communities it can work very successfully. Much of it depends on the skill of the worker, his ability to handle the group, his awareness of transference and counter-tranference feelings, and his sensitive use of casework and group therapy techniques.

Another factor that should be considered as a realistic hindrance to the formation of groups in small communities or in sectarian agencies in large communities is the difficulty of finding homogeneous groups with similar problems. There may not be enough mothers of latency-aged youngsters or adolescent girls being seen for out-patient treatment. The aged may have come for a variety of problems, ranging from requests for homemaker service because of illness to problems of depression due to isolation or death of a marital partner. It may be impossible to find enough cases at any one time where the problems or the age group are similar.

This is a realistic problem, and it is not easily solved. Even if one could find such cases in an agency's caseload, one must also consider other factors in the cases that might make it inadvisable to refer all these cases to the group. These are difficulties in scheduling mutually convenient group therapy hours; problems of client motivation for treatment; and the previous involvement of many of these clients in individual therapy. Frequently, agency caseworkers as well as the clients involved in individual therapy find it difficult to switch therapists and make the transfer to group treatment.

There is also the fundamental issue of treatment method of choice, whether it should be individual treatment, family therapy, group therapy, or some combination of various forms of therapy.

With all of these realistic as well as emotion-laden factors that affect the formation of groups, I suggest that we must look at the problem from a new perspective if we wish to form and continue group therapy in our agencies, be they large or small. If we have the conviction that group therapy is a desirable method and should be part of the program in any treatment agency, then we should be more imaginative and flexible in the formation and selection of groups.

For example, we should include in the group women who have problems with young children as well as those with adolescent children with emotional problems. We should feel free to include

adults who came primarily because of marital problems. We should experiment with bringing husbands into existing groups that are composed only of women, or we should initially form mixed groups.

There may be marked disparities in the ages of individuals involved. Some women may be in their twenties, others may be in their late forties or fifties. We can anticipate some of the problems that may arise. The more experienced or older women or men may tend to dominate the group. The younger women may develop mother transferences, either positive or negative, to the women in the group who are twenty or thirty years older. Good! These are difficulties but they also pose some interesting possibilities for treatment. Their interactions will present material that can be handled by other members of the group and by the therapist. The individuals can be helped to see some of their reactions to older siblings, to their mothers, and to authority figures. The older individuals may develop increased awareness as to how their reactions to their younger sisters or their children are exemplified by their attitudes to the younger members in the group.

In other words, the problems that smaller agencies and sectarian agencies in larger communities face in initiating and retaining group therapy in the agency are many. But if "necessity is the mother of invention," it also applies to our uses of group therapy. It leaves room for more inventiveness on the part of the staff in forming groups composed of mixtures of different types of individuals. It challenges the staff to develop their skills in order to better handle problems of confidentiality and the transference problems that occur in any group. In the end it is more likely that agencies that are forced to adapt their methods to fit the needs of their clients will have more dynamic groups and will make more significant contributions to the mental health of their clients as well as to the field of group therapy.