Article

group analysis

Clinical Wisdom

Kristian Valbak

A diversity of cultural, economic and social factors influence our professional work as psychotherapists, and hardly anything we do with our patients is not dependent upon society's political and moral choices. Moreover, what can be regarded as wisdom is difficult to agree upon, more so for group analysts. It must be felt wise, maybe more easily seen at a distance, and best found by asking men or women, in whom we trust.

This article will explore fundamental ideas and assumptions regarding the art of helping patients by psychotherapy. The focus is on group analytic psychotherapy and the use of it in psychiatry. Some of the questions are: What shall be modified in the method and technique to make it helpful to the patients, and will it be possible to meet the requirements of validation from the public health services? Can research and the researcher be of use in group analysis and do we at all have a mutual case?

Clinical knowledge from psychotherapy research and retrieved reflections from wise colleagues, on what can be regarded the most essential experiences in therapeutic groups, are presented. Emphasis will be on the therapist's personal development and existential challenges.

Shakespeare's tale about 'the choice of the three caskets' illustrates some moral choices, which can also be regarded as choices for the therapist.

Key words: wisdom, group analytic psychotherapy, clinical guidelines, evidence-based practice, research, therapists' values

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Introduction

'Clinical'[1] has etymological roots in the Greek word 'κλίνή', which means 'bed'. Therefore when I talk about clinical wisdom, it will be my professional and personal experiences as a group analyst in psychiatry–experiences with persons, who suffer so much, that we call them patients.

To find wisdom[2] in this 'Islands of the beds' some would consider an impossible mission. I am thankful though to be given this opportunity to reflect upon those challenges I have found in the art of helping patients by group psychotherapy in a clinical setting.

What can be regarded as wisdom is difficult to agree upon, more so for group analysts. It must be felt wise, maybe more easily seen at a distance and best found by asking trustworthy men or women.

Should I fail in conveying wisdom, consider this my professional creed. It is obvious that we have very different possibilities in life. Our well-being and perception of life is highly dependent on our social position and economic possibilities.

As Marx phrased it:

> It is not the consciousness of men that determines their being, but, on the contrary, their social being that determines their consciousness. (Karl Marx, 1859)

The Context

Denmark–where I come from–was once the centre of an empire but is now a small country and the people in it have a small state mentality, a long tradition with democracy, equality and trust towards regulatory state institutions. In addition, freedom from war and larger natural disasters makes us the happiest and the most trusting people in the world. Strangely enough we also have 450,000 people (approximately 1/10 of the adult population) on anti-depressant drugs and the highest consumption of alcohol in Europe among young people.

The Danish Mental Health Service is tax funded and free. Only a few psychologists and psychiatrists in private practice offer psychoanalytic or group analytic psychotherapy. Long-term psychotherapy is uncommon both in the public health sector and in private practice mostly because there is little demand from wealthy buyers. A small psychoanalytic milieu is located in Copenhagen.

The Psychiatric University Hospital in Aarhus–rated in 2013 as the best in Denmark–was built in 1852. The number of psychiatric beds in Denmark has declined by 75% in my professional lifetime (1974–2011). Of the hospital's 223 beds, progressively 22% are occupied by forensic patients.

In the 20th-century the most important improvement for psychiatric patients was not the development of the psychopharmacological drugs, but the sheltering of psychiatric patients, providing them with sufficient nutrition. Patients with schizophrenic illnesses died in early age from tuberculosis. It is ironic and of much concern, that a patient coming for the first time to a psychiatric emergency room today, statistically will die 18 years earlier than another person without a psychiatric diagnosis. Why? Because of addiction, excessive medication and–bad nutrition (Aagaard, 2013)!

Hardly anything wise or important regarding the care we provide for the mentally ill and disabled, will not be dependent on political and economical choices. If one looks at the operating budgets for the health sector in Denmark, 'psychiatry' is 40% lower than other medical specialities. Nowhere else it is easier to see the face of oppression and discrimination in the society towards psychiatric patients! This spring it has been estimated that Danish psychiatry needs 2.5 billion kroner (that is 336 million Euros) to be up to date. But there is no political will to do this.

The Group Analytic Clinic in Aarhus

The Group Analytic Outpatient Clinic in Aarhus was established on the premises of the Psychiatric Hospital in 1986. A small team collect and forward referrals to the once a week, slow-open group analytic psychotherapy groups. The therapists have at least three years group analytic training *or* receive continuous supervision from the group analytic training programme in Aarhus. During the last 10 years the number of groups has been reduced from 24 to 14. Retirements without replacements and low priority given to this kind of treatment are frequent causes in a time where diagnosis-based package-dosed treatments take the autonomy from the psychotherapists, who increasingly are psychologists, trained in CBT. So far however, there has been no direct demand on group analytic treatment and the average treatment time–estimated to be three years–has not been restrained.

Before the assessment interview patients are asked to write a letter, in which they tell their relational story, significant life events and how they imagine the group, where they are expected to stay for at least one year. Many patients do not initially see their problems as relational, but are easily guided to that insight. All patients fill out a booklet of questionnaires sent from the secretary 'before', 'after' and 'one year after' therapy. If schemes and feedback forms are meaningful for the patient and the therapist can handle the exchange dynamically, they have a synergistic effect on the therapy.

It is of greater concern that talented, new-born group analysts from the training in Aarhus often experience, in their first group analytic groups, early and late drop-outs, often with serious consequences both for the patients, the groups and for the therapist's self-confidence. One could speculate that their ability to contain psychic pain and handle counter-transferential feelings has been insufficiently developed during training. Or could it be that supervision has been too sparse? Their own view is that mostly it comes down to patient factors.

The patients 'available' in the hospital setting have been increasingly disturbed and disorganized through the years, and the group therapist must manage very difficult group dynamics with severe regression, malignant mirroring and acting-out. Patients cannot cope with the frustration and the anxiety initially and their 'needs' are not met by the group.

So Who is Group Analytic Psychotherapy for?

Foulkes started group analytic psychotherapy in his private practice in Exeter. He said:

> When group analysis is used as a method of psychotherapy it is called group-analytic psychotherapy. (Foulkes, 1964: 231)

A variety of patients with different diagnoses were taken into his groups, but in general they presented a high degree of social functioning:

> Out-patient conditions, that is to say people who pursue their usual lives uninterruptedly whilst undergoing treatment. This is the chief domain of this type of treatment. (Foulkes, 1964: 231)

Most patients referred to the psychiatric services will not be in this category. Therefore selection and assessment of patients is indispensable—not only to find the right patients for the group, but also to create the right group for the patients. Sometimes I wonder about the modest interest this topic has been given. Patients just do not join groups and participate with increasing enthusiasm until they finish. The high rate of drop-outs in groups–from 25–60 %–must always be a challenge. Especially borderline patients will act out and leave, if caution is not taken.

Already in 1990 Malcolm Pines–in a chapter called 'Group Analytic Psychotherapy and the Borderline Patient' –concluded:

> It is not possible to treat a group made up entirely of borderline patients. (Pines, 1990: 95)

The recurrent question has been, can group analytic psychotherapy be modified, and then applied to all kinds of patients? One can argue that group analytic psychotherapy always–more or less deliberately–has been adapted and modified for attending patients. Foulkes' use of groups to treat traumatized soldiers is an example of such a set assignment. Since then several articles about applied group analysis have been published, also about borderline patients.

Group analytic psychotherapy does not work as a standard and I think it is artificial to distinguish so called 'classical' group analysis from 'applied' group analysis equal to group analytic psychotherapy (GAP).

Sylvia Hutchinson thought about it. She said:

> . . . the operation of group specific therapeutic factors described by Foulkes such as mirroring, exchange, condensation etc. can all be enhanced or restricted by adaptations of group-analytic method. (Hutchinson, 2010: 8)

> It is my view that group analysis *is* an applied discipline–it is the application of certain principles and basic assumptions, using a methodology, (creating a group-analytic situation), that can be adapted according to the task and the context. (Hutchinson, 2010: 9)

However it is neither in the mental health sector nor in private practice the general view, that group analytic psychotherapy holds this great therapeutic capacity for a variety of patients. And I think much more can be done to promote group analytic practice and alter that view.

Ambivalence to Research

Data based research has never been a popular interest among psychoanalysts. During the years a small number of colleagues–usually psychiatrists–have advocated a stronger engagement in clinical research–from small scale research (Whittaker, 1976; Kennard, 1990; Mace, 2006) to large scale effectiveness studies (Lorentzen, 2002; Wilberg, 2003; Karterud, 2011; Tschuschke, 2013). They have often been met with little attention or frank scepticism.

In December 2009, initiated by the Management Committee of GAS, a special task group provided us with an update on 'the evidence' of the benefits of group psychotherapy obtained from process and outcome research (Blackmore et al., 2009).

In summary, most studies indicated that group psychotherapy is beneficial, regardless of therapeutic orientation. Success criteria in these studies were not emancipation, often not even ability to 'love and work', but the relative freedom from symptoms, improvement of relationships and more satisfaction with life.

For some the sparse production of articles on GAP was nothing new, others felt disappointed that 'research' could not be more supportive of our method. Renewed criticism was raised both of the positivistic research approach and of the intrusive and meaningless quality reports demanded by the management of NHS.

Strong opinions were tabled with concerns, that the idea and identity of group analysis would be damaged and 'exploration of free associations in group' turned into 'newspeak', a controlled language created by the totalitarian state in Orwell's '1984' (Campbell, 2010).

In a commentary to Karterud's and Lorentzen's GAS presentations in 2011, Richard Blackwell gave his fellow members a political lesson about our alienated situation. He wrote:

> Like rabbits trapped in the headlights of global capitalism, dazzling us through the National Health Service and the job market, we have started to freeze our own capacity to think. (Blackwell, 2011: 13)

And he continued:

> We fail to note that justifying our existence may involve prostituting our art as a 'better' technology of social control than the thought-policing of CBT or the chemical and electrical coshes of old style psychiatry. (Blackwell, 2011: 13)

I am not sure how general this critical voice is in our society. I cannot believe it is an attack on psychiatrists and psychologists working with group analytic psychotherapy in psychiatry. Does it reflect a fear that group analysis could lose its distinctive character by modification? I believe on the contrary. The development of group analytic psychotherapy in psychiatry will contribute to further interest, recruitment and acquaintance with group analysis.

Working more than 30 years as a psychiatrist, I am of course not unfamiliar with the repressive forces of psychiatry and the inevitable contribution I have in this. But we all take part in this repression. The exclusive mechanisms in society are ever working, expelling, moving and isolating madness to places like psychiatric hospitals, where particularly murderous aggression towards others and towards oneself can be tamed and obliterated.

Evidence Based Treatment and Practice Based Wisdom

When the original recommendation on how to do evidence based treatment was published, the 'scientific evidence' criterion became over-emphasized for ideological reasons. The critical assessment of whether the research results were relevant and the therapists' own judgement and experience became largely forgotten. Today we talk about 'evidence based practice' defined as 'the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences' (APA, 2005: 17).

This drift in the understanding of the 'evidence' concept has many reasons, for example 1) A better understanding of the limitations of the 'Randomized Controlled Trial' and the value of 'the naturalistic study' in psychotherapy research; 2) More research confirming that psychoanalytic psychotherapy works; and 3) Reports that CBT has failed as a general method with an experienced need for a more comprehensive theory.

Let me now give some examples of what I for the occasion will call 'Practice Based Wisdom':

1. Group psychotherapy is effective and as good as individual psychotherapy, for some patients better (McRoberts et al., 1998).
2. Good 'quality of relations' in earlier life and 'psychological mindedness', which is the opposite of being personality disturbed, are good patient assets and predict successful outcomes (Valbak, 2004).
3. Groups suffer from drop-out. Therefore selection, assessments, preparation and motivation are important. Infusion of hope is important to raise motivation (Alarcón, 2012).
4. 'Therapeutic alliance' is the most important predictor for good outcome. In the group it corresponds to good 'cohesion' and trust in the group (Norcross, 2002; 2010).
5. Non-specific factors are more important than method. It matters more, how the therapist and the group are (Assey and Lambert, 1999).
6. Transference interpretations are not that important and can be counterproductive (Ogrodniczuk and Piper, 2003; 2008).

Piper and co-workers found in 1991 an inverse relationship between the proportion of transference interpretations and both alliance and outcome. In a later study they examined the last session prior to drop

out for typical patterns. Qualitative analysis of the therapeutic process indicated that sessions typically started with patients expressing dissatisfaction or disappointment with treatment and therapists responding with transference interpretations. As the patients continued to withdraw or express resistance, therapists often continued to focus on transference issues. Sessions often ended with patients agreeing to continue treatment at the recommendation of the therapist, but never returning (Modified from Baldwin and Imel, 2013).

7. When groups are in distress, the more disturbed patients are abandoned by the therapist. The therapist must be aware of imminent ruptures of the alliance and immediately address them (Stiwne, 1989).
8. Patients with low ability to mentalize must have more structure and support and less regression. This can be provided by the therapist–also in groups (Valbak, 2003; Karterud, 2011).

In the article *How Do We Make Group Analysis Suitable for 'Non-suitable' patients?* (2003) I described my work with bulimic borderline patients in a long-term group. With a modified method, there were very few drop-outs, and the outcomes were good (Valbak, 2003).

Karterud (2012) was radical in his conclusion that borderline patients need more support than the analytic groups can provide. He suggested a mentalization based treatment (MBT) with a special structure, privileged themes and a certain therapeutic stance, that imply 'a considerable deviance from commonly agreed upon group analytic principles'. What that means exactly, is of course the key issue.

Bateman and Fonagy's frequently cited Randomized Controlled Trial research on personality disordered patients (Bateman and Fonagy, 1999; 2001) has gilded mentalization based treatment and very effectively promoted this structured technique with groups as helpful for the borderline patients and easy for psychiatric staff to access.

A recent article in *Group Analysis* by Potthoff and Moini-Afchari argues that 'mentalization' procedures are embedded in group analytic psychotherapy.

> Mirroring, marking, validating, and above all the ability to verbalize previously non-verbalized affects are inherent in every group session. Groups have a unique

> potential to mirror self-states, object-relations and affects. (Potthoff and Moini-Afchari, 2014: 6)

My view is that a detachment of group analytic psychotherapy from the treatment of this kind of patients is a moral and professional surrender and a retreat from playing a role in psychiatric treatment.

At the World Congress on Personality Disorder last year in Copenhagen most of the presentations were about treatment of borderline patients and bottom line of research was, that any method was as good as the other including a structured, 'good clinical treatment'. Most presentations were about individual psychotherapy. Group analytic psychotherapy was only represented by the Norwegian research team.

Textbook on the Practice of Group Analytic Psychotherapy

The diversity among group analytic psychotherapists is large and the variety of therapeutic groups is almost infinite. GAP is exercised in numerous ways and fashions that all differ from a norm we could call Group Analysis, the Therapy. In general the effectiveness of GAP will not differ from other forms of group psychotherapy.

There are already good descriptions and guidelines for other group psychotherapies (Bernard, 2008; Montgomery, 2002; Karterud 2012). While group analysis can exhibit a prolific literature of theories in books and articles also on applied group analysis, there has not been a comparable body of knowledge about group analytic technique for the practitioner of GAP. If we want GAP to be a part of psychiatric treatment also in the future, we need more specified descriptions of a modified group analytic method and technique, preserving essential features of group analysis.

For the purpose of meeting research recommendations Steinar Lorentzen wrote a manual on how to conduct long-term and short-term dynamic groups. The manuals have been translated and published in English (Lorentzen, 2014). One should note that both modalities are of time-limited, closed groups. Guidelines for the 'long-term' groups build on traditional group analytic theory, while the short-time group has been added so called 'activating and supportive elements' slightly modified from McKenzie (1997). With the limitations described, I find this manual an important contribution to the technique and application of GAP and a useful teaching material in training. What stands in the way of a 'good enough' textbook or manual is an idealized and narrow view of GAP.

Gabbard writes:

> Perhaps the most significant challenge facing those who would like to provide a manual of psychoanalytic technique is the loose relationship between psychoanalytic theory and clinical practice . . . Theory and practice have progressed at very different rates–practice has changed in only minor ways relative to the major strides made by theories. Moreover, psychoanalytic theory is largely not about clinical practice. (Gabbard et al., 2002: 509)

Curiosity is in the centre of our work both in research and in therapy. But the ways we take to expand our knowledge are different, from an epistemology based on hermeneutics to epidemiological research based on quantitative data. Theory is important as a common ground. 'Transference' is a theory as is 'the social unconscious'. Theories are hypotheses or models we use to explain and understand. If one theory fails, we must look for another.

Else Margrethe Berg from Oslo is concerned that we lose knowledge that is tacit and conveyed non-verbally. This kind of knowledge cannot be accounted for by explicit operations. She finds the approach of the researcher and the therapist completely different.

She says:

> . . . it is always necessary to be vigilant so that the things that increase our technical competence do not interfere in a negative way with the encounter and the open dialogue . . . It means that if we are not active in assigning sufficient value to meaning, context, narratives, subjectivity and dialogue, the processes that enhance self-development will suffer. (Berg, 2009: 156)

I agree with this view. It is true that research represents a selection and reduction of data, but I also believe that this is a part of any process of understanding. I think the point is how we *interpret* these data.

To the question of validation *we* must decide what evidence we need and how we can present it? It is a grandiose idea and a denial of reality that we–working in the public sector–can be totally free from evaluation and regulation.

I believe different ways of acquiring knowledge can exist side by side. Group analytic psychotherapy may be subject to both hermeneutic and positivistic research methods. As Whittaker has put it:

> Ideally, "hard", quantifiable data forms a framework for qualitative data such that the former contributes discipline to one's findings and the latter provides richness and detail. (Whitaker, 1985: 161)

There are several factors not less important than theory and research that influence our practice as psychotherapists:

- Working conditions (environmental culture)
- Regulations
- Payment
- Prestige
- Ideology (altruism)
- Personal preferences (countertransference)
- Role models such as supervisors and trainers

The Therapist

The most important factor is probably–what Grotjahn (1987) named–'my favourite patient'.

Who are we and why did we choose to become therapists? My experience is that many of us come from difficult family structures and have had traumatic experiences. I agree with the notion that we are highly sensitive and from childhood have developed skills of observing other family members' behaviour, and that we are relatively alert and mistrustful of oppression and authority.

Both Freud and Foulkes saw personal therapy as mandatory. The training to become group analyst must make us see, that we are indeed patients ourselves. We must know ourselves and our own suffering to see and understand that in the other.

Jung wrote:

> For psychotherapy to be effective a close rapport is needed, so close that the doctor cannot shut his eyes to the heights and depths of human suffering. (Jung, 1989: 166)

Foulkes warned against persons that were too eager to help others. If we suffer from 'the helping profession syndrome' we will become frustrated and depressed ourselves. EGATIN's Essential Training Standards suggest 240 hours personal therapy as a minimum, strangely enough, taken from Foulkes' recommendation of group therapy for three years to be sufficient for most patients.

Foulkes saw training as

> . . . a unique occasion for working through the countertransference problems of the future psycho-analyst. (Foulkes, 1964: 139)

Figure 1 My favourite patient (5 weeks old)

Despite training Foulkes was not optimistic about the therapists gain:

> . . . he is frequently not as free from disturbance as he should ideally be (Foulkes, 1964: 139)

Training–I think–must be a foundation, not an end to a process of learning that will go on to the end of our lives.

In general no research can support a clear connection between training and skilled performance–and good outcome of therapy. However, one of the most significant and consistent results of research is the finding, that non-specific factors–including therapist assets–play a major role for a successful outcome. Some of the most effective therapists have been described as passionate, diligent, feedback interested, and resilient (Duncan, 2008).

When Are We Good (enough) Group Analysts?

The duration of personal therapy in the European Institutes varies from four to eight years (Valbak et al., 2011).

In EGATIN we sometimes discuss the value of (long) training. Does the investment influence the subsequent practice? Does it make a difference for the therapist or for the patients? I think nobody can answer that question.

The decision as to what it takes to be ready to practice group analytic psychotherapy is very culture dependent. The closer to a psychoanalytic tradition, the longer is the 'need' for personal development. I will advocate that it should not last too long before the candidates are 'allowed' to practise group analytic psychotherapy. One strong part of the training in Aarhus is the requirement to establish and run–initially an applied time-limited patient group–and after that a long-term slow open group analytic group for more than two years. This turns out to be a strenuous task, but rich in learning. A Norwegian study (Hoestmark Nielsen, 1999, from Berg, 2009) revealed that a group of questioned psychologists considered 'working with patients' as the most important factor in helping them become clinical professionals.

Some uncertainty about training can also be found: If it is 'qualifying'. There is a need for recognition at all levels: The personal level, the professional level as group analysts and at the organizational level of the training. Being a 'good enough' training institution seems to be a vulnerable issue among peer institutions. Envy, rivalry and inferiority feelings alternate with relief, gratitude, inspiration, hope and . . . recognition.

Evaluation can be threatening. It exposes whether our performance is superior, comparable, or inferior to our peers. What group analysts actually do in their group, we do not know much about. Some of us are quite confident about our work, others–I suppose–sometimes fear, that we do not do it correctly (that is in accordance with Foulkes). Are we good group analysts?

Walfish and co-workers (2012) asked mental health professionals in private practice to compare their overall clinical skills and performance to others in their profession. 25% assessed themselves to be in the top 10% of skills and performance and none viewed themselves as below average!

The authors suggest that a therapist may substitute a positive view of what a client received from therapy to soften feelings of failing a client. I am inclined to believe that these findings are not so much different in our own ranks. As psychotherapists we must not be too self-absorbed and complacent.

Remember Kierkegaard's wise reminder:

> . . . all true helping begins with a humbling. The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve; that to help is not to be the most dominating but the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understanding what the other understands. (Kierkegaard, 1859: 45)

Listening is a virtue that we praise. Listening to patients . . . and to each other!

The Search for Therapeutic Wisdom

In my search for therapeutic wisdom I decided to ask 12 wise men and women, who have been in the profession for a lifetime:

> . . . what experience in the therapy group has had the most important positive influence a) on your patients in the clinic; b) on your training candidates in the training groups, where you have been the training analyst; and c) on yourself as member of a therapeutic group?'

Here are samples from their answers (author's shortening, translation and emphases):

> . . . the interest in other group members with similar difficulties and symptoms and *the break through from separation and relative autism*, which that kind of revelation can bring along. For my own part what I remember best from my own training in group is the group leaders way of working—which later took me a long time to avoid getting stuck with. (G. Ahlin, 2014)

> If it's a choice between talking about the individual or the group I almost always steer it towards the individual. I talk about the group only when I think the group is in trouble. I hardly ever make a so-called transference interpretation between me and the group (negative or positive). It wastes time and weakens the container function of the group. I work towards helping each group member to feel special in a good way. *This often corrects a lifetime of family and social stupidities.* (H. Behr, 2013)

> It is these moments . . . of profound existential meaning, of being met and being understood . . . a profound experience which has the power to change your direction in life . . . an experience that also has a touch of 'corrective emotional experience', but which transcends this more narrow concept. Moments of meetings are facilitated by a group therapist who is authentic in his discourse and behaviour and who shares relevant emotional content of his or her own mind. (S. Karterud, 2013)

> *To preserve the value of truth* is mandatory. If we think the truth is too hard for anyone or may be felt as an aggression, the wise choice is to abstain and wait for a later possible moment. *When I make a mistake I clearly state it and apologize.* An interpretation should have the contribution of several members of the group, if possible. (C. Dinis, 2013)

> I have become wiser as a therapist! The most important issues are a) to have a depth of knowledge; b) to re-assess oneself daily, so as to realize, what was a

> relevant and useful clinical technique; c) to have an excellent personal analysis; and d) to look deeper into what is discussed, rather than superficially. (S. Rastumjee, 2013)

> . . . to bring people out of isolation through providing *a constant and reliable structure*, and connecting and attaching to a network of relationships within the *safe, structured frame* of a group analytic therapy group. The *experience of belonging* that can accompany being part of a resonating matrix can enhance one's sense of being-in-the-world. A 'corrective' group experience is a crucial change factor for many patients. (Hutchinson, 2013:)

> Patients become better by working through in a regressive analytical process in a group mainly through transference, mirroring and resonating their inner group relations which cause their symptoms. *They change if they in a trustful group analytic situation can open up their hidden and shameful feelings, fantasies and traumatic life experiences and share it with the other group members.* (W. Knauss, 2014)

> The group cohesion and the acquirement of a space, where you could say things about yourself that you never told anyone before and still be accepted. There was also a lot of humour and of course the therapist had a major role for one *feeling safe.* (G. Winther, 2014)

> To be accepted despite what 'the others' have seen and heard (and perceived as shameful and repulsive). The experience of 'being able to help' and 'to be with others'. Important qualities of the therapist are calmness, knowledge, curiosity, flexibility, and therapeutic authority. (Aarhus Teachers Group, 2013)

Should I conclude anything in general from this, I will say that the most important experience in group analytic psychotherapy is the feeling of being included in the group. It can be as a feeling of 'belonging' or in a moment 'being met' and understood. Safety and trust are important facilitating circumstances–all well-known factors. One colleague mentions the ability to tolerate one's own mistakes in the group, and thereby communicating that the therapist is not 'perfect'. Some were dissatisfied with their own therapist and mention difficulty in separation and finding independence.

I am deeply grateful to you for sending me these reports. I guess it was hard to answer with short notice, but I was looking for your experiences–unpolished. Moreover your contributions buttressed my insecurity regarding the whole project and it was relieving to discover that my own experiences have many similarities with yours.

Wisdom of Life

Myths and tales are vehicles for universal dilemmas and wisdom. One of Shakespeare's plays will illustrate some of my points. The Merchant of Venice has a little embedded fairy tale: The choice of the three caskets.

The suitor–or shall we say–the psychotherapist must choose the right casket of three to get the princess, that is to do right as therapist and in life.

The first suitor who chooses the golden casket and gets 'what many men desire', receives the following note:

> All that glisters is not gold;
> Often have you heard that told.
> Many a man his life hath sold
> But my outside to behold.
> Gilded tombs do worms infold. (Shakespeare, Merchant of Venice II.7)

The second prince chooses the silver casket and gets 'as much as he deserves'. He must leave the scene as 'deliberate fools':

> When they do choose,
> They have the wisdom by their wit to lose. (Shakespeare, Merchant of Venice II. 9)

The leaden casket bears the inscription:

> Who chooseth me must give and hazard all he hath.

In Bassanio's short speech while he is choosing the casket, he says of lead:

> But thou, thou meagre lead
> Which rather threaten'st than dost promise aught,
> Thy paleness moves me more than eloquence. (Shakespeare, Merchant of Venice III. 2)

Freud (1913) argues that the three caskets are three women and that the leaden one, which Bassanio had to choose in order to win Portia, is the Goddess of Death. So if the choice between the women is free, why choose death? Bassanio's choice is not of death, because death is normally not to be chosen, but the choice to face the fact, that mortality and loss and grief is an inevitable part of life.

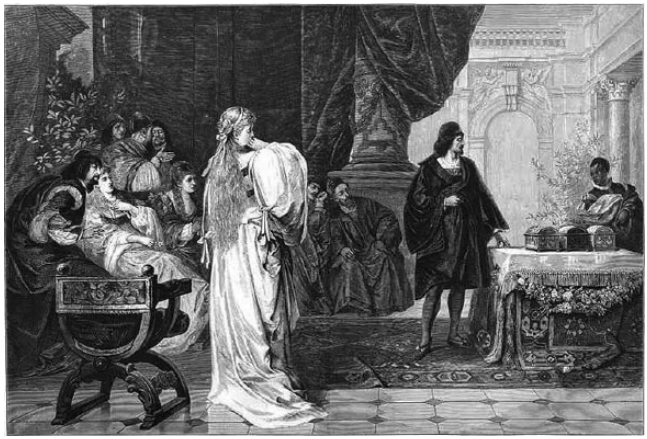

Figure 2 Bassanio with the three caskets

Roger Money-Kyrle wrote about life's misperceptions, which we have to mature from. The third and last misperception is that we are immortal! We must recognize 'the inevitability of time, and ultimately death'. Recognition of this fact is connected to the experience of weaning, as the prototype for subsequent loses–that all good things have to come to an end (Money-Kyle, 1978).

Therapy is a Moral Endeavour

Looking back, it has been difficult for me to distinguish my professional values from my personal values, which I probably have conveyed to my patients and trainees in my groups. Nor could I distinguish the meaning of therapy with the meaning of life. The curiosity I have for other humans is the same in therapeutic relations as in other relations.

More or less there have been the same questions in my life as in the patient's life. The same challenges, the same choices, the same horrors and the same beauty. 'Knowing yourself is the beginning of all wisdom' said Aristotle. 'Do not be superficial, do not become complacent and be brave enough to face reality', said Shakespeare. And then remember the words on Marx's memorial, as a voice from the grave:

> The philosophers have only interpreted the world in various ways. The point however is to change it. (K Marx, 1845)

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Notes

1. Clinical means 'related to patients'.
2. Wisdom is the ability to think and act utilizing knowledge, experience, understanding, common sense, and insight' [Wikipedia]

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