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Preparing for Group Analytic Psychotherapy: Meeting the new patient

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Preparing for Group Analytic Psychotherapy - the patient and yourself as a therapist - is apparently done in many ways and still invested with much controversy and ambivalence. Some say, they do no selection or assessment at all. The patients or clients are taken from the waiting list in alphabetic order. Other therapists - mainly those working in National Health Services - use several assessment interviews before including patients into short- or long-term groups. Either way, this paper revives some research results about assessment and hopes to inspire therapists in their first contact with the patient by presenting some examples from a clinical outpatient practice in a Mental Health Service.

Key words: assessment, Group Analytic Psychotherapy, preparation, suitability, alliance

Why assess?

The word 'assessment' is derived from the Latin 'assidere', 'to sit by' but it has also the meaning of formally evaluating (often in money) assets belonging to somebody (Holmes, 1995). The double meaning of the word assessment can be seen to represent the dialectic between the interpersonal and in principle unpredictable and, on the contrary, the objective validation of assets.

Assessment is not therapy, but it should have the quality of improving the understanding of the patient's situation and what is needed to make a change. Reasons for doing assessment with patients in the Mental Health Service are as follows:

1. To find the best match between patients' needs and the available therapeutic possibilities. That is to fit the patient to a specific therapy group and vice versa. There is also an expectation to make therapy as effective as possible!

In general, assessment became relevant when 'cost–benefit' procedures became pertinent - and when psychoanalysis and long-term psychotherapies were replaced by short-term approaches.

2. Drop-out is a major issue in group psychotherapy and has costly consequences for the patients and the group. The initial interviews can reduce that problem by building therapeutic alliance and offering the patient more of a realistic idea of therapy already in the interview.
3. To allow the therapist to gain a more profound impression of the patients mental structure.

There are also reasons why assessment is not so extensively used:

1. It is a difficult and time-consuming procedure.
2. We do not feel comfortable with this procedure, since we might end up by refusing the therapy to a patient.

3. We are convinced that the group will handle it and catch up with our omissions.

Referrals

To be able to fill the groups we need referrals! The better informed colleagues are about the objectives of group therapy, the more likely the referrals will be appropriate. In institutional settings, advocates of group therapy may need to be developed within the institution to sustain the group therapy enterprise (Burlingame et al., 2004). The administrative role of the therapist includes taking time to nurse the referral system offering information and feedback (Behr and Hearst, 2005)

The group analytic clinic

A Group Analytic Outpatient Clinic was established at the premises of the Psychiatric Hospital in Aarhus in 1986. A small team receives the referrals and distributes them to the therapists of - for the time being - 16, once a week - slow-open Group Analytic Psychotherapy groups. The therapists have at least 3 years of group-analytic training or receive continuous supervision from the group analytic training program in Aarhus. The patient groups meet where the therapists find it most convenient, and the hospital has reserved two rooms exclusively for Group Analytic Psychotherapy.

Pre-therapy information from the patient

After reading the referral papers, the patients are asked in a letter to describe their relational story, significant life events and expectations for the group. It is expected that they agree to stay at least 1 year. This letter has been for a long time the ticket to the assessment interviews. However, increasingly few men did write a letter, which unbalanced the 1:3 gender ratio even more. Therefore, the request for the letter is now sent together with an invitation for the assessment interview.

Below is a handwritten letter from a 22-year-old female student of music. Severe anorexia that started when she was 14, with several admissions to psychiatric departments, disrupted the family. She was placed in foster care without contact with her mother and felt like an orphan. She writes,

> I have the feeling of being less worth, less talented and not deserving my place at the study. I do not trust others or do it too much. I suffer from break downs and feeling of emptiness. I feel like a miserable person, cannot do anything good, neither to myself nor towards my fellow humans. I feel lonely, even though I have so many people around me. Nothing gives meaning and often I don't feel I deserve to live. I expect to work with my low self-esteem and my picture of reality and my lack of overview, so I can avoid the recurrent depressions, which come and go. Simply how shall I cope with my strange mind and feelings? There s so much else to say than what I have written here, but I would like to make it short for your sake. Hope that it is sufficient. Best regards . . . . (Clinical vignette I)

It is not difficult to get in touch with her pain. The letter speaks of one of the most basic relational difficulties that bring patients to treatment, namely, the feeling of being excluded and not belonging anywhere. This woman can probably be helped, if she manages the initial challenges in the group and stays at least 1 year.

Purpose of the letter

As Chris Mace (1995) has pointed out, the letter procedure has several advantages. Besides giving factual information and saving time for the therapist, it engages and prepares the patient for the interview.

How patients choose to provide the information requested allows insights into a patient's attachment style. Some patients very directly express the expectation that the therapy and the therapist must provide them with immediate help. But it is not clear for the patient, what he or she has to do himself or herself.

The drop-out problem

Studies show that 30%–50% of patients, who start in group psychotherapy, drop out (Christensen et al., 1991). It varies with the duration of the group therapy and with the experience of the therapist. The first generation of group analysts at the psychiatric hospital in Aarhus suffered many drop-outs from their groups. A total of 30 patients or 56% dropped out during the first year of treatment (Christensen et al., 1991). To investigate this further, the following design was created:

> 75 blinded written-out assessment interviews were distributed to the 10 therapists. They should then nominate the ten *most group-attractive* and the ten *least group-attractive* patients from the population. The therapists choices were announced at a big table meeting, and during a two hour long discussion, choices were argued and reasoned and criteria for 'suitable' and 'non-suitable' patients were distilled. (Valbak et al., 1990)
> Negative signs in the patients' earlier history were: 'Abuse' and 'admission to psychiatric hospital'—which can be understood as low and unstable social functioning. A plus was 'earlier experience with psychodynamic psychotherapy'. Moreover it was suggested that the interviewer should inquire about earlier group experiences: In the school, in sport activities, as a scout, soldier and so on. This gives precious information of relational problems, also—and that is the point—for the future therapy group.
> To gain information about the patient's defense and anticipation of the group, the interviewer was recommended to ask the patient: 'What can happen in the group that could make you wanting to leave'. And: 'Can you image that the verbal interchange we just had, could be in the presence of the group?'

The described scenery has the possibility of exploring - in the here-and-Now - a group situation with a potential frustrating experience. In the impossibility of having pre-group experiences, these dyadic assessment 'exercises' can be a compensatory alternative. Foulkes' (1975) practice of having an introductory interview in groups, letting the discouraged go, which shrinks the group to 8 from originally 12 members, or—as Yalom (1985)—to have introductory courses from which patients were directed to the therapy groups requires a sufficient amount of patients and groups and considerable time for administration and assessing.

Some goals of the interview

The assessment interview requires some planning about what is to be done in the time set. The author usually does two interviews, the first, 1–1.5 hours; the second, 1 week later for 1 hour.

The interviews aim at the following:
(a) Establishing rapport with the patient;
(b) Obtaining pertinent information about the patients;
(c) Offering information;
(d) Giving hope by enabling the patient to feel understood;
(e) Giving the patient a taste of the treatment;
(f) Motivating the patient to pursue treatment;
(g) Selecting treatment for the patient (after Tantam, 1995).

It is difficult to separate meeting from assessment, because meeting with the other is a prerequisite for the assessment. However, the

quality of the meeting, as it can be instigated by the therapist, is fundamental for the development and potential of the assessment.
While assessment of the patient's assets and the exploration of his ability to a possible gain from joining a specific group is the primary task, meeting is essential for the patient's relation to the therapist and starting a therapeutic alliance. The building of trust and belief in the therapist and the group is of utmost important for the initial adaption to the group milieu.
When the assessment has been done, a decision must be made—together with the patient—whether or not to offer him a place in a group. Selection is often a judgment if the patient can make use of the group, often a specific group.

Diagnoses and psychodynamic hypotheses
Diagnoses are usually required everywhere in the Mental Health Service. The *Diagnostic and Statistical Manual for Mental Disorders* (*DSM*) and the International Classification of Diseases (ICD) are the classification systems, and the semi-structured interview SCID-II is frequently used for a personality disorder diagnosis.
However, many psychotherapists find the ICD and the *DSM* systems of limited value, because they are categorical and phenomenological based.
It is, however, advisable to get an impression of each patient's personal matrix, before they embark into the group. Collection of the patient's history should focus on relational problems with members of the original family, present problems with persons of other and same sex, to spouse, children and to significant others, like superiors at work. All symptoms should as far as possible be brought into an interpersonal context.

Cyclical Maladaptive Patterns (CMP) is an example of a dynamic conceptualization of the patient's problems, that is, to find a smaller number of penetrating themes, which dominates the patient's life and can be traced back to his or her personal history, and then explain how the patients attempt to solve these central—often relational conflicts—has become maladaptive (meaning: producing symptoms and character pathology) and adaptive (characterizing his or her general stile regarding pleasure, work and personal relations). The central conflicts—conscious and unconscious—link and explain important patterns of behavior and usually contain elements hidden for the patient's attention (Butler and Binder, 1987).
These patterns will appear in a dynamic interview, which—in vivo—exposes the patient's personality and defenses and indicates how transference will unfold in the upcoming therapy.
Kernberg's structural classification of the organization of the personality (at a neurotic, borderline or psychotic level) was based on the patient's 'identity', 'maturity of defense mechanisms' and 'ability to test reality':

It was a hot day and late. I was alone at the psychotherapeutic department like the week before. The patient came for the second interview and started out with this statement: 'It was all wrong, what we did the last time!' He was a rather big and heavy man; his voice was deep and sounded a bit sinister. I did not have a clue what he was talking about. It took some time to find out, that he believed, I had invited him to engage in a sexual relationship. The circumstances were, that when I locked him out through the departments double glass doors, which functioned as a storm flap, I stretched my arms out like to embrace. While I held the two doors simultaneously, he had to pass me closer than expected. This gave rise to the thought, that I had made a pass at him. After talking through the other alternatives, he left the paranoid position and 'moved' from a psychotic level of mental

organization into the borderline organization. It came out that he was unsure about his sexual preferences and had thoughts about leaving his wife. (Clinical vignette II)

Operationalized Psychodynamic Diagnosis (OPD-2) is an interview-based instrument that builds on Kernberg's structural interview, but the structure dimension is more explicitly operationalized and it includes the modern interpersonal theory on relations and modern developmental psychology. OPD has the potential of examining the level and character of possible personality difficulties, which could have important impact for the length, preparation and process of the psychotherapy. Lately, the use of OPD-2 for preparing clients for short-term group psychotherapy has been investigated with promising results (Oestergaard et al., 2014).

Suitability

Suitability for Group Analytic Psychotherapy can be understood as the interaction of at least three interdependent variables: the patient, the therapist, and the group.
In a predictor studies on 'suitability' and outcome, the strength of this capacity was measured by the following variables obtained from the Dynamic Assessment Interview (Valbak et al., 2004):

- Patients' motivation;
- Psychological mindedness;
- Tolerance of frustration;
- Ability for self-observation;
- Capacity for empathy;
- Ability to show and sustain affect (emotional freedom);
- Response on confrontation.

Although significantly correlated to outcome measures—as in other similar studies—the correlations were too small to be of use for selection in clinical practice.
Reviews of articles on patient variables and good outcomes from dynamic psychotherapy (mostly individual) have found the highest correlations for these variables:

- Quality of object relations (QOR)

This predictor is designed and developed in Canada by Piper et al. (1991). The QOR patient personality characteristics were assessed by an unstructured interview conducted just prior to the onset of therapy. It was defined as 'a person's internal, enduring tendency to establish certain kinds of relations with others' and takes into account the lifelong pattern of the person's relationships.

- Motivation for change

The strength of client's motivation for treatment is strongly related to length of stay in group therapy. A Norwegian study found that patients with high 'Motivation for change' consistently had more favorable outcomes. This factor was equivalent with an 'active engagement factor' meaning that the patients realized that psychotherapy was a collaborative effort. The patients should know that it was expected that they were willing to explore, experiment with and change their own behavior (Hoeglend, 1996).

- Psychological mindedness

'Psychological mindedness' means that the patient is aware of an 'inner life' and shows interest in psychological processes, for example, dreams. Included is some self-observing capacity and emotional freedom.

Indications for group

Can we say what kinds of problems indicate Group Analytic Psychotherapy? The bold statement of Foulkes (1975) was, 'Group Psychotherapy is indicated whenever psychotherapy is indicated'.
We can also agree with these general indications, suggested by Rutan and Stone (1993): (1) problems to attain or sustain authentic intimacy and (2) relational problems.
For group patients, it is often possible to transform the symptoms presented by the patients into relational problems. The patient might complain about anxiety, but he can learn, that the anxiety breaks out, when conflicts are arising with the spouse, or in front of an authoritarian boss.

Exclusion criteria

Traditional diagnostic contra-indications include acute psychosis, severe schizoid withdrawal and schizoid personality. Research from the Day Hospital Program in Oslo showed that patients with a *DSM*-IV cluster A personality disorder receive only minor benefits from the group psychotherapy, compared to patients with cluster B and C disorders. And interestingly enough, the combination of criteria was more predictive, than just the fulfillment of the diagnostic criteria (Karterud, 1999)
Inability to follow group rules (to keep the contract), overt destructiveness, suicidality and substance abuse are other traditional criteria for exclusion. One of the most difficult situations for the therapist is to be forced to dismiss a patient from the group, if, for example, a patient becomes psychically threatening. That can suddenly become a matter of survival of the group.

What do we say after we said hello?

Foulkes used questionnaires and schedules with a highly personal coding. During the courses of the trial groups, he posed these questions to the patients:
1. Which problems do you have?
2. What makes you seek help now?
3. What thoughts have you had about our meeting, before coming here today?
4. What kind of feelings did you register connected to that?
5. How can these conditions change?

The prompting of the transference feelings (question numbers 3 and 4) must be mandatory. A patient, who can answer all these questions, will be well suited for psychotherapy.
Using the relation and focusing on the process, a dynamic interview has a large potential for revealing dynamic structures in the patient and building therapeutic alliance. If you can get through to the patient, using the tool of psychoanalytic psychotherapy (empathy that is), and make the patient feel understood, you create the necessary positive expectation and give hope to the therapy.
Making a psychodynamic hypothesis takes some exploration in the patients' past, his childhood and development. It usually crystallizes during the interview and can often be 'confirmed' in the transference. It can also be presented, discussed and negotiated with the patient:

I think our conflict started already in the doorway, when she entered my office for the first interview. She was a 26 year old, slim and sulky looking woman referred to the group analytic clinic because of two experiences in public where she felt very dizzy and uncomfortable. After that she was reluctant to walk the streets unless accompanied by her husband, a two years older architect, who followed her

for the first interview. What happened in the doorway was that I requested to talk with her alone. As a consequence her husband sat outside the door for more than 1 1/2 hours. In the interview she mentioned troubles with dominating men and incompetent therapists she had met earlier. Finishing the interview I suggested, she came alone the next time and avoided taking tranquillizers for stressful situations like today. She returned the week after without her husband and she was furious about my requests. Her brother in law, who was a psychologist, supported her opinion that I could not make these demands. Moreover she found my behavior very authoritarian. For example: I had pointed out in which chair to sit and had opened the door before she finished putting on her coat, when she was leaving. And I should explain what kind of therapeutic training I had?
I suggested we had a fight about who decides in the upcoming therapy, and that she was afraid what would happen if I would 'touch' her. After a little elaboration on this interpretation, I suggested that she thought about it and offered her joining a group if she found the hypotheses interesting and wanted to find out more. (Clinical vignette III)

This example of a first meeting with a patient illustrates the importance of motivation and being able to challenge anxiety. It is my general rule to see the patient alone without support and have focus on the patient–therapist relationship.
This story also illustrates how the transference is immediately installed with the therapist as the authority that would like to dominate her. She fiercely protested against this. A common countertransferential acting would be to punish her by rejecting her ('I am sorry you cannot join the group, because you will not fit in'), which would be a revenge on her accusations. Equally problematic is to be very subservient with her and, for example, in detail answer her questions of my training and experience with groups. A mistake would also be not to address her dependence on tranquilizers. Her devaluation of

the earlier therapists is a good indicator of what to expect in the transference. An initial hypothesis was that she was struggling with her own anger and authority, being unable to dominate unless in neurotic disguise, for instance, by having her husband to be with her all the time:

She attended the group for more than half a year, but never really joined the company of the others. Besides being quite inactive, she sometimes kept on her overcoat, pulled her chair away from the circle, took warm tea into the group from home and left the group for a while in the middle of the session to go to the bathroom, where I suspected she took a pill, which subsequently made her dull and sleepy.

It is most important that the patient get a taste of what therapy might be like: frustration, insight, surprise, reflection, analysis and interpretation. And if possible show them the group room!
It is important to make the patient feel that time has come for something new, 'a new beginning'! They must believe in the group (and the therapist). Discuss with the patient what kind of obstacles, you think, he will find in the group. Predict his difficult moments and discuss with him what to do.

Instillation of hope—also in the assessment interview
Years ago, I interviewed a group with young bulimic and personality disordered women. They were referred to the group analytic long-term group—where the average stay was 3 years—from the Clinic for Eating Disorders, where a short-term group treatment had been ineffective:

One day a severely bulimic patient Sandra entered for interview, dressed in black, tense and with eyes everywhere else but on me. The situation had recently grown to the worse. She was a compulsory long distance runner and did that every day to

loose calories, but now unable to continue because of a stress fracture in her knee. She very quickly started crying saying that she had been in several groups before and all un-successfully for her. Now she was without hope and had little faith that this new group could do anything for her. Buttressed by the good outcome already with similar patients, I told her, that this group could suit her, because it was especially designed for those who had failed in other groups. I explained that it was a very exclusive offer and I thought she would fit in perfectly. After the two interviews she met for the first time with the group and sat listening intensely to the other group members. Luckily she had to dismiss her expectation that the others would be much more disturbed and even more important she noticed than one of the members had moved from a position that sounded very much like her own to a much more empowered position. (Clinical vignette IV)

The starting point of a patient assessment for group psychotherapy is the firm conviction that group psychotherapy is an effective form of psychotherapy—as effective, if not more effective, than individual forms of psychotherapy (Burlingame et al., 2004; McRoberts et al., 1998). Realistic, positive expectations of change are more likely with this knowledge and there is significant evidence regarding the impact on outcome of positive client expectations at the start of psychotherapy (Seligman, 1995). Many patients in the Mental Health Service come demoralized without expectations or with doubt that anything matters anymore. Instillation of hope in the interviews will often be the first step to make a therapeutic alliance and later to cohesion.
If the patient has an abuse problem, for instance, of anxiolytics, alcohol or cannabis, it is advisable to evaluate the severity of the abuse and the patient's attitude towards it. Some patients wish to keep their addiction away from therapy, concretely by not talking about their intake of alcohol or pills, unconsciously by splitting off the addictive side of the personality. Later when relapse occurs during stress in the therapy group, the result can be narcissistic injury, unbearable shame and drop out.
At the same time, it is important not to split off the social functions. Does the patient have a job? Is he looking for work? Or is he applying for a social pension? Is the patient referred by social security in order to make him more suitable for work? Each and every of the mentioned conditions would have a decisive influence on the course of the therapy, its success or failure.

Contributions by the therapist
Some clinicians have provocatively claimed that there was only one question necessary to predict successful outcome of therapy, namely, to ask the patient after a couple of sessions: 'Do you like your therapist'? And vice versa.
Some say that we unconsciously already after a few minutes have decided whether the patient shall be offered therapy or not. This attraction to the patient is legitimate, but could be severely influenced by countertransference. We must seriously take our thoughts about the patient: Are we unusually concerned? Attracted? Irritated? Stuck with? Forgetful? Are we telling things about ourselves which we usually don't? Make extra assessment sessions or can't we leave the patient in time? It will probably be countertransferential feelings to be analyzed.

Contributions by the group
Even if a patient is considered to be appropriate for group treatment, the question remains which type of group is most suitable. The therapist can choose to be more active and influence the balance towards more patient–therapist interaction in a group analytic group and in

this way we technically make the group more structured and supportive. Sometimes it is wise to realize that most patients come to the health service just to get what is necessary and nothing more. Some patients do not share our passions for introspection, and sometimes their pessimistic ideas about what psychoanalytic therapy can bring them are well in place.

Psychoanalytic psychotherapy in contrast to cognitive behavior psychotherapy has its advantages with non-focused problems, with interpersonal difficulties as it is the case with personality disorder patients or with focused problems where a psycho-dynamic hypothesis can be created. Focusing follows as a necessity from shortening the therapy, and for a good deal of patients, it is rational and appreciated.

Composition of group

There is not likely to be an 'ideal' group in terms of composition variables, but rather particular group climates that are more facilitative of constructive change for particular kinds of group members.

Yalom (1985) considered that the patients in any particular group may well need to be at a similar level of functioning, while Foulkes (1975) held the opinion that the wider the diversity, the higher the therapeutic potential—as long as the group is capable of coping with this diversity without disintegrating.

That means selecting for sufficient heterogeneity to ensure group resources varied enough to generate warm, responsive interactions between some group members and (the courage to face) inevitable confrontations with others and with sufficient dissonance to provide alternate role models for more effective ways of behaving and coping with stress.

There is an important difference between taking patients to a new group and including patients in an already established group. In the mature group, new patients will quickly learn the already established group culture. Most important is that they can get hope by learning how other patients have grown to cope with their problems. It is important every group starts to take care of the patients who do not relatively quickly feel comfortable and help them to express their feelings which usually after all are shared by the other members.

Some borderline organized patients will have an inclination to expose themselves too much and to be fearful afterwards (fear of having destroyed the group or the therapist) which could lead to a situation where drop out is felt as the only way out.

Especially in the beginning of a patient's group life, the therapist must be tuned in on imminent alliance ruptures. If a new patient feel neglected for just one session, despair and anger can prevail and a drop-out may result. If the group can provide the patient with enough empathy and understanding, so he or she feels included, we can expect a good outcome.

Conclusion

This clinician's[1] suggestion: For group, take the patients who have a desire and are willing. Take the patients you can relate to in the assessment interview and whose problems you can empathize with. Don't rush through the assessment interview. What you have earned here, will bless you later. The preparation of you and the patient are the foundation for a successful group process, and the patients can learn of life from the assessment interview—even if they are not taken into therapy.

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Note
1. The author practices an applied pluralistic modern group analysis, influenced through the years besides Foulkes and Bion, by Freud, Bowlby, Winnicott, Pines, Behr, Nitsun and Karterud. The running of homogeneous and short-term groups has been influenced by American group psychotherapy represented by Yalom, Rutan & Stone, MacKenzie and by Lorentzen. The theoretical foundation regarding the assessment lies with the object relational standpoint of Kernberg and Selzer. Theory about the importance of the therapeutic alliance and the writing of Frank about the attitude of the therapist have shaped the purpose of the interview.

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