AN ANALYSIS OF TRAINING REQUIREMENTS FOR PRACTITIONERS OF GROUP THERAPY IN THERAPEUTIC MILIEUS

by

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This dissertation is submitted in
partial fulfilment of the requirements
for the degree of Master of Social Science
in Clinical Social Work

School of Social Work
University of Cape Town

1982

ACKNOWLEDGEMENTS

I would like to express my appreciation and thanks to Dr E Nash - Senior Psychiatrist and Senior Lecturer in the Department of Psychiatry, whose goodwill has made this paper possible and who gave generously of her valuable time to discuss the therapeutic milieus with me.

I would also like to thank Mr Andy Dawes of the Department of Psychology and Mrs Verna Nel, Senior Clinical Psychologist in the Department of Psychiatry for providing me with the relevant information about group therapy training on the Clinical Psychology Master's programme; Miss Gail Resnick - Psychiatric Social Worker in Ward D12, Groote Schuur Hospital, for her help in obtaining information about the Psychiatric Nursing training programme and for clarifying details of the Ward D12 therapeutic milieu programme for me; and to Mr Gerrit Van Wyk, Clinical Psychologist who alerted me to the need for an Association of Group Therapists.

I would like to acknowledge my debts of gratitude to Mrs Celeste Steele who, as my lecturer and supervisor in group therapy on the B.Soc.Sc.(S.W.) Honours course in Psychiatric Social Work, introduced me to the practice of group therapy and instilled in me my enthusiasm for this method of therapeutic endeavour; to Miss Beryl Berrangé, Senior Lecturer in The School of Social Work, who became my guide and mentor in learning the art of groupwork supervision and who has continued to encourage and aid my development in this field; and to Mrs. Ruby MacDonald for her skill in deciphering my handwriting and hard work in typing this dissertation for me.

Finally, I would like to express my thanks to all the Psychiatric and Medical Social Work students who taught me how rewarding supervision can be and especially those students in the 1981 Psychiatric Social Work Honours class who agreed to allow me to use their process records for this dissertation.

University of Cape Town, May 1982 Valerie Moss-Morris

CONTENTS

ABSTRACT

In order to assess the need to formulate training requirements for practitioners of group therapy in therapeutic milieus attached to the Cape Provincial Hospital service, the organization, theoretical framework and functioning of these therapeutic milieus have been outlined. The group therapy component of the therapeutic milieu programmes and the present training provided to all four psychiatric disciplines from whose ranks the co-therapists of the therapy groups are drawn have been examined.

Within this framework an assessment of the need to provide both improved training and some considerable training in common for the four psychiatric disciplines involved has been made. Evidence from the writer's observations reached during three years of supervision of psychiatric social work students' group therapy practice in the therapeutic milieus together with examples from the students' process records has been cited to support the conclusion that these needs do exist.

The training requirements have been analysed into four components: the theory, experiential group attendance, group therapy practice, supervision. The formulation of a training programme embracing these components is advocated.

It is concluded that the training programme should to a great extent be applicable to co-therapists from the different psychiatric disciplines.

Finally a number of proposals as to how improved and common training programmes can be evaluated and implemented have been outlined.

PART I

An Assessment of the Need to Formulate Training Requirements for Practitioners of Group Therapy in Therapeutic Milieu Practice Placements

1. INTRODUCTION

The practical training in psychiatric social work of post-graduate students of The School of Social Work at the University of Cape Town is undertaken in a number of psychiatric settings in the community of Cape Town. The major placements used are the psychiatric units and wards operating within the Provincial Hospital Service of the Cape, viz. the psychiatric in-patient units at Groote Schuur Hospital and Avalon, the Psychiatric Day Hospital at Groote Schuur and the William Slater Hospital for Alcoholics. These units are basic training placements for all the psychiatric disciplines, i.e. for Psychiatric Registrars, Clinical Psychology Interns, and Psychiatric Nurses as well as for Psychiatric Social Workers. Training in Group Therapy is an important component of the training programme for all these disciplines.

Following her observations made during three years experience of supervising the group therapy practice of psychiatric social work students within these placements, the writer has concluded that it is necessary to formulate some proposals regarding the training requirements for the practice of group therapy by psychiatric social workers in such settings. In view of the fact that the group therapy is conducted by co-therapists drawn from all the psychiatric disciplines as well as the Occupational Therapy staff of the units, it will be contended further, that these training requirements apply to all these disciplines. The fundamental need is that there should be at least some considerable areas of training in common for group therapy.

Before training needs can be considered it is necessary to have an understanding of the theoretical framework and the

organisation and functioning of these units.

2. The Therapeutic Milieu Approach

All these units function within the framework of a therapeutic milieu. As Anderson and Trethowan (1973) point out the basic concept of milieu therapy is that the psychiatric patients' surroundings, both physical and interpersonal should be therapeutic, i.e. such a unit should become part of the treatment not just a place where treatment is given. In its most highly developed form the therapeutic milieu is known as a therapeutic community where the focus is on the interpersonal milieu rather than the physical structure.

Professor Otto Kernberg in an address at the Cassel Hospital Diamond Jubilee Conference in 1980 outlined the traditional therapeutic milieu model (as developed by Maxwell Jones and Tom Main). This model uses the principle of community therapy and active patients. As he points out (this quotation is from a resumé by Dr. E. Nash of his address)

> the therapeutic culture results in re-education and social rehabilitation, aiming at optimal social functioning both in the community and eventually in society; these living, learning confrontations in the here and now can lead to the exploration of alternative behaviour; much attention is paid to group meetings, small, large and special purpose, in which open communication is practised, social behaviour is encouraged, rehabilitation skills are rehearsed and decisions are arrived at in a democratic way.(1)

According to Maxwell Jones (1968) the therapeutic community concept involves a redistribution of power, authority and decision-making and a more democratic egalitarian social structure generally. The single powerful staff leader is gradually replaced

by a group of leaders, in other words there is a flattening of the authority structure.

The therapeutic community or milieu is thus staffed by a multi-disciplinary team consisting of psychiatrists, psychiatric nurses, clinical psychologists, psychiatric social workers and occupational therapists. In line with the philosophy of an egalitarian social structure role distinctions within the team tend to be blurred.

Kenneth Myers (1979) discusses this concept of blurring in his article 'The mental hospital therapeutic community in recent years' in Therapeutic Communities. He points out that Maxwell-Jones' basic idea was "to release staff and patients from the rigid straight-jacket of traditional role expectations in order that each individual could make the fullest contribution compatible with his personality, knowledge, skills and problems"(2). When seen in this light, this idea seems to have considerable value. However, Myers, along with other critics, feels that the consequences of the concept 'blurring' which means 'making vague or indistinct' (dictionary definition) does a serious disservice to the therapeutic community movement. He suggests that it creates unnecessary confusion and anxiety in both staff and patients and thus, unnecessary dissension within the community as a whole. From this writer's own observations, made during supervision, it would appear that blurring of roles also exacerbates competitiveness, both conscious and unconscious, within a staff team. The resultant dynamics can often be damaging to the interests of the patients.

Professor Otto Kernberg (1980) questions the supposition that authority, unless it is restrictive, is anti-therapeutic. He believes that when a therapeutic community model is implemented there needs to be clear administrative structure, clear task definition, lines of authority and accountability, preservation of staff expertise and avoidance of role diffusion; that each professional has a differentiated role function although each perform some common functions. As a result of this type of critical evaluation the organizational structure of present day thereapeutic milieus has been modified to a certain extent and although they are still staffed by multi-disciplinary teams lines of authority are more clear-cut and there are usually leaders in the teams, or leadership rests in the hands of consultants.

Treatment procedures in milieu units in hospital settings include medical treatment e.g. prescription of drugs, individual psychotherapy and therapeutic activity, occupation and social intervention within a variety of group settings. Thus, the focus of treatment is on both the intra-psychic stresses and the psycho-social factors that affect patients. To develop treatment skills in both these areas Professor Kernberg (1980) has emphasized the value of the use of two theoretical models, viz. the psychoanalytic model and the systems model.

Maxwell Jones (1976) sees the basic aspect of the therapeutic community or milieu programme as being the daily community meeting of the entire staff and patient population. These meetings are used to examine the issues in the system, e.g. the emotional processes of staff and patients, the functioning of the social system;

the use of power, the impact of social factors on emotional life and any administrative issues. He believes, however, that it is desirable to follow these large meetings by group meetings consisting of a small group of patients because many tensions cannot be worked through in a community meeting. These tensions act as a stimulus to communication in the smaller meetings. This is where the group therapy component of the programme becomes necessary. Group therapy meetings provide the micro-milieu in which emotional processes and the impact of social factors and interaction can be examined and worked through in greater depth with the aim of improved functioning of the group members. Thus 'group therapy is primarily a social and pyschological process in which an emotional re-educational and re-learning experience can occur.'(3) The requisite for group therapy is the employment or utilisation of the services of a trained conductor who is a professional person using specialized skills to accomplish his/her goals.

3. The Organization, Theoretical Framework and Functioning of the Therapeutic Milieu Placements attached to the Cape Provincial Hospital Service

a) Organization

As the aforementioned placements operate within a therapeutic milieu approach, with the focus on the interpersonal milieu, they will be referred to in this paper as the therapeutic milieus.

They are staffed by a multi-disciplinary team as described in the previous section.

Authority and responsibility for treatment planning rests

in the hands of the staff. Leadership allocation is tradition-bound and thus remains in the confines of the medical profession so leadership roles are filled by consultant psychiatrists and psychiatric nurses.

Some blurring of roles exists. The role of individual psychotherapist is filled from the ranks of Psychiatric Registrars, Clinical Psychology Interns, and Psychiatric Social Workers and Psychiatric Social Work students. Group therapists are drawn from the ranks of all the psychiatric disciplines and in some units, from the Occupational Therapy staff.

(b) Theoretical Framework

The theoretical framework is eclectic and rests basically within the psychodynamic and systems models. However it is influenced and enriched from other sources notably the field of behaviour modification.

(c) Functioning

There are variations as regards the treatment programmes within the therapeutic milieus. William Slater Hospital, for instance, has a brief three week in-patient therapeutic milieu type programme. This is followed by treatment on an out-patient basis. In Ward D12 at Groote Schuur patients remain as in-patients for as long as three or four months. There are the usual ward rounds, staff meetings and staff groups. As far as the patient's programmes are concerned, there are a variety of group activities which include inter alia evocative techniques, growth games, social skills and other aspects of occupational therapy.

Community meetings, individual psychotherapy and group therapy are the basic components to be found in all the milieus.
As the group therapy component is the focus of this paper it is necessary to outline it in more detail.

(d) Group Therapy

In the in-patient milieus at Groote Schuur and Avalon the group therapy meetings are held for one hour per day, four times a week. There are two groups, viz. an orientation group and a working group. All newly admitted patients attend the orientation group unless there are contra-indications of a reasonably severe nature. Anorexic patients during their early phase of weight gain, overtly psychotic or brain damaged patients do not go into group therapy. Selection criteria are not considered in terms of the narrower perspective of suitable composition for the group therapy groups. This would make admission criteria too complex.

However, there are some selection issues which should perhaps be kept in mind in view of the fact that the group therapy component is a very important part of the programme. This writer considers that one of the selection criterion that should be considered is that of suitable age range. She questions, for instance, the wisdom of placing adolescent patients in group therapy with adult patients. For example, she observed a group session in which there were inter alia three middle-aged women and one adolescent girl of 15. The three adults were working on the issue of coming to terms with the imperfections of parents. The girl was in the adolescent developmental phase of rebelling

against parental authority so was unable to work on this issue. Expectations that she could do so would be totally unrealistic. As a result she became a disturbing element in the group and was scapegoated both by the other members and the therapists.

The focus of the orientation group is on educating group members to think psychologically and on developing a group ethos. When it is felt that patients have reached a stage when they are able to work on themselves with a view to symptom relief; attitude change, improved reality testing, improved ability to relate to others and possibly some personality change, they are transferred to the working group. Thus,in principle the working group functions at greater depth. In practice, of course, if cohesion occurs in the orientation group a working phase can be achieved in this group too. On occasion this group can work as well as if not more effectively than the working group. Admission to the working group depends on both psychological readiness and a vacancy occurring through discharge of a patient. Some patients do not progress beyond the orientation group.

Both groups are thus open groups with a changing membership and are on-going with no clear-cut beginning or termination phases. The groups are led by co-therapists. Students or trainees from all four psychiatric disciplines are required to act as group therapists as part of their training programme. Because there is a need for all students to get a turn and because conducting group therapy is demanding and tiring even for the trained staff there is a change of therapist every four to six weeks. To achieve some stability co-therapists move in and out at different

times so there is an overlap of leadership. This means that group members are not faced with two new therapists at one time.

Change in membership and leadership is not so rapid that no stability can be achieved. Group cohesion does occur in both groups. Nevertheless, the constant change does create many difficulties and at times appears to be therapeutically hazardous. The separation anxiety reactivated can become so high that it cannot be worked through in a beneficial manner.

Wherever and whenever possible students with little or no experience are placed with more experienced co-therapists. However, there are often administrative difficulties in this regard and there are times when both therapists are inexperienced. The actual experience of so-called experienced therapists is relative and may consist of as little as one year's experience of running groups.

There is no consistent, intensive, in-service supervision of the trainee group therapists. Groups are held behind the one-way mirror so that any staff who wish to do so may observe a group in session and provide the therapists with critical feedback.

At the Psychiatric Day Hospital there is only one group which all patients attend. This is held for one-and-a-half hours each day four times a week. This is also an open group run by co-therapists who change every six weeks. Medical students and other students may sit in as observers. To date there has been no one-way mirror in the Day Hospital premises so staff observation and feedback have been unavailable.

At William Slater, a new group of patients is admitted each

Monday. For the three week in-patient period they attend daily group therapy meetings for 50 minutes a day. These groups are also run by co-therapists from the different disciplines. They are,however, closed groups and have the same co-therapists for the three week period. After discharge patients attend out-patient groups on a weekly basis.

4. The Present Training of the Group Therapists

(a) Psychiatric Registrars

They have no formal theoretical training in group therapy. Their training is thus entirely in terms of practice. This is their first experience of running a group. They have no special group therapy supervision but have intensive individual supervision of their total therapeutic practice.

(b) Clinical Psychology Interns

They have a few formal lectures/seminars and attend an experiential group once a week for a short period during their Honours course.

In the first year of Clinical Master's training they attend an experiential group once a week throughout the year. In addition they are expected to run a weekly group outside of working hours for a period of six months. Some supervision is given. Many students run the out-patient groups at William Slater.

In the second year of their internship they go into in-service training in the various milieus and other psychiatric settings. Part of their training is therefore conducting the group therapy groups as one of the co-therapists. They are given intensive individual supervision of all therapeutic work done.

Where a one-way mirror is available they are observed by their supervisor on occasion. From her observations of actual practice the supervisor can pick up whether they have any understanding of group processes. They are not expected to write process reports on their group therapy practice as, by this stage in their training, they are expected to have their basic understanding of group dynamics and process.

c) Psychiatric Nurses

Prior to going into in-service training on the ward they have a series of four lectures on group therapy which includes some input on group processes. They also attend an experiential group once a week for the whole year of their training period.

Once assigned to a milieu or unit they are expected to take part in all the activities on the programme including conducting the group therapy groups as one of the co-therapists. This is their first experience of working in a group. They are expected to get feedback from the sister-in-charge or any other staff who observe them, but have no intensive supervision of their practice.

d) Psychiatric Social Workers

In undergraduate training in social work, social groupwork is one of the major social work methods taught. At the University of Cape Town social work students are given lectures on groupwork in their first, third and fourth years. They also attend a series of workshops on groupwork in their third and fourth years. As part of their practice component in their third year they run an activity group with therapeutic goals for one hour a week for 10 weeks. These are closed groups. They have to write full process

reports of each meeting and attend weekly group supervision sessions in addition to a minimum of 3 individual supervision sessions.

In their fourth year they elect to specialize in either community work or casework and groupwork. For their groupwork practice they again run a group of a therapeutic nature once a week for about 10 weeks. They are expected to take more responsibility in the selection and composition of this group, and if possible they both run a group and act as a recorder in another group. Supervision is given on similar lines to that given in the third year.

When psychiatric social work training was given on an Honours degree level group therapy was a full-time theoretical course and practice consisted of selecting and conducting a closed therapeutic group for one to one-and-a-half hours once a week for 14 to 16 sessions. Students acted as leaders in one group and recorders in another. Weekly group supervision, for which full written process records were required, was given once a week. Each student was also given a number of individual supervision sessions. For the last three years of the Honours training the formal lecture input was replaced by a compulsory programme of prescribed reading and an experiential group. Those students doing their practical placement in the therapeutic milieus used this experience as their supervised group therapy practice component.

Post-graduate clinical training is now being done on a Master's degree level. The formal content of this training programme is still in the developmental stages. At present the group

therapy training consists of a half course of formal lectures/ seminars; attendance of a 10 week experiential group and supervision of group therapy practice which is undertaken in a variety of placements including the therapeutic milieus.

It can thus be seen that the background experience and present training of the four psychiatric disciplines is of very different levels.

5. The Need for Improved Training

As Henry Walton et al (1971) point out the ability to conduct a psychotherapeutic group is a complex technical skill. Whether the group therapist takes an active role or a very non-directive stance he/she remains the most important person in the group and needs to recognize and maintain his/her role of authority figure. A therapeutic group may have no clearly defined task nor may the therapist impose any activity or issue on the group. This does not mean, however, that the therapist should not give direction to the group. As Johnson (1963) suggests the group therapist needs to have a constant awareness of doing group therapy not individual therapy within a group.

Colby lists the following qualifications and requirements for a psychotherapist:

1. A body of knowledge concerning normal and pathological thought and behaviour in our culture.
2. A logically cohesive group of theoretical concepts which are convenient in understanding this thought and behaviour.
3. Technical experience in therapeutically integrating observations with concepts in clinical work with patients.

4. Intuition as a practised and controlled ability to read between the lines and empathically grasp what the patient means and feels beyond the face value of what he says.
5. Awareness of his own inner wishes, anxieties and defences and their influence on his therapeutic techniques. (4)

The group therapist in addition needs a body of knowledge concerning group dynamics and group processes; a set of theoretical concepts to aid understanding of these processes and an intuitive ability to grasp the latent as well as the manifest content of these processes.

It is important to remember that therapy groups per se are not automatically of therapeutic benefit. If the therapist is lacking in understanding and skills groups can become what Henry Walton et al (1971) term psychonoxious.

They point out that

> Group discussion inevitably mobilizes conflict and tension is generated. Highly morbid beliefs can be expressed and gain currency. Marked psychological resistances can develop so that erroneous belief can persist. (5)

In a large-scale controlled research inquiry into the effectiveness of encounter groups undertaken by Lieberman, Yalom and Miles in 1973 they found that one-third of the participants had undergone moderate or considerable positive change. The remaining two-thirds had found it an unrewarding experience either because they dropped out, remained unchanged or experienced negative change. In fact, 8% of the subjects actually suffered psychological injury which produced sequellae still present six months after the end of the group. Although this study was of encounter

groups, encounter groups and therapy groups have sufficient in common for results to have applicability in both fields.

In the writer's own experience of supervision she can cite the following example of a period of 22 group therapy sessions held in one of the therapeutic milieus in which, in her opinion, nothing of therapeutic benefit and some psychological damage occurred. It is in fact this incidence which was the motivating force behind the writing of this paper.

In the group in question a psychiatric social work student acted as one of the co-therapists for all twenty-two sessions. She was supervised by the writer. This was the student's first group therapy experience. The evidence for the writer's conclusion that nothing therapeutic occurred was drawn from the student's process reports. Allowance must, therefore, be made for the student's bias. The reports were, however, written in sufficient detail for the writer to be able to pick out a number of clear-cut latent themes that persisted throughout this phase of the group's life. During this period the student worked with three different co-therapists.

When she first entered the group she was faced with a lot of hostility from group members. It was clear that much of this hostility was linked to the termination of her predecessor. In this group no attention was paid to phases of group development or to group processes. Thus termination feelings were never recognized, dealt with or worked through, and the group members were always carrying within them unfinished business with regard to separation issues. The student had, in fact, moved into a period

of group mourning for the departed therapist. Members were thus not ready to form new attachments. As a result of her reception by the group the student felt inadequate and she became locked in an unconscious competitive battle with her co-therapist in an attempt to become the 'good' therapist in the eyes of the group. In addition she had a need to be accepted by patients on a peer level so was not comfortable in her role as authority figure. As a result of this she related to her co-therapists in a manner that tended to move them into becoming an elder sib-subgroup on a latent level. As the student was the only therapist in supervision this could only be worked through with her and not with the other therapists.

In the fourth meeting there were still issues of trust prevalent in the group (typical of an orientation phase of group development). As neither therapist was looking at the group in terms of group development they did not respond in an insightful way to testing out by group members. As a result the theme of the fifth meeting 'If we are not good we will lose the love of mother' was not picked up. This seemed in fact to be the overall theme of the*milieu at that time. As the group therapy was only one component in the overall programme it was clearly influenced by and influenced the total milieu culture. From verbal reports of the student the staff of the*milieu seemed to have developed a very confronting, often punitive approach to patients. In the group therapists used a lot of confrontation, often needling patients in order to get them to express anger but positive feedback was seldom if ever given. No attention was paid to the

* therapeutic

development of caring norms. The student was confronted with this by her supervisor but when she fed back criticism on this score to the other members of the team she found that they were not receptive and she became very defensive about introducing a norm of caring herself. A feeling of antagonism towards the social work staff and the University social work supervisor developed in the team.

In the following five meetings a lot of anger was expressed towards staff. Some of this was attached to reality issues. A lot of the anger that is evoked in a therapeutic group is of course triggered off by the basic conflicts with parents and other authority figures in the patients' past. If this anger is accepted and worked through in a caring atmosphere and with understanding by the therapists an emotional re-educational experience can be brought about. This did not occur.

In the tenth meeting the group theme was an expression of a need for belonging and acceptance.

In the fourteenth meeting the student's co-therapist was terminating, having completed her period of duty as group therapist. The termination was again not worked through so termination anger was being expressed in a sideways manner and the latent theme that emerged was 'Mothers don't care for us'.

The new co-therapist had a very confronting style and started confronting patients in her first meeting. Again a lot of anger was being expressed against staff by the group. On a latent level the group appeared to be a group of siblings looking for the parenting care that was not coming through to them.

The student felt more comfortable working with this second co-therapist and was beginning to model on her style. One of her learning needs was, in fact, to learn how to confront but in her supervisor's opinion this needed to be used with diagnostic awareness.

In the seventeenth meeting the theme centred around envy of the closeness of the therapists. By the eighteenth meeting the group members had also learnt the art of confronting so were attacking one another and the theme that emerged was 'We don't even care about each other'. In the nineteenth meeting yet another co-therapist took over, showing no understanding of group process or of the fact that patients needed to build up trust in her. In the twenty-second meeting the student was terminating and the group members were still desperately testing out the therapists. In this meeting they rejected a statement that staff did in fact care for them. This was summed up in an angry retort that the staff were paid to care for them.

So in twenty-two meetings the group was still stuck on issues of trust with regard to caring and had thus never reached a point of working on their problems in a way that could promote positive change.

At this point the writer felt it necessary to intervene and a meeting was arranged with the whole staff team of the therapeutic milieu. The writer explained that she felt nothing of therapeutic benefit had occurred in twenty-two group therapy sessions. She suggested that some of the reasons for this were:-

a) that a non-caring and rather punitive culture had developed in the *milieu as a whole.

* therapeutic

b) that none of the therapists involved appeared to have any understanding of group development or process except the student under supervision who had begun to develop awareness in this area.

c) that the therapists used mainly confronting techniques without any diagnostic understanding or assessment of their interventions.

d) That, as a result of these three factors, no caring norms were created in the group so insufficient trust was developed for cohesion to occur.

e) that no staff planning, in which conscious goals for both the group and the individual members were thought through and articulated, took place.

f) that as staff had not been trained to pick up the themes of group meetings there was no way of assessing progress.

Analysis of the student's records was cited as evidence. The team was justifiably rather resentful of an outsider coming in to criticize an aspect of milieu functioning. It was to their credit that they were prepared to listen and ask for suggestions. A month later the student once again went into the group as a therapist. The team had clearly taken the issue of the need to create caring norms to heart. This one factor alone paid remarkable dividends and the group was able to work through the initial issue of developing trust and to develop periods of cohesion in which some intensive and beneficial work was done by a number of the group members. However, the writer still felt that there was a pattern of using techniques without any diagnostic understanding.

In her role as supervisor of group therapy practice in the therapeutic milieus the writer has become increasingly aware that appropriate and successful intervention is dependent on sound diagnostic thinking. The following example provides a graphic illustration of poor use of a technique much in vogue because of its dramatic qualities.

A seventeen-year old boy S. attended his first session in the orientation group in one of the *milieus. Both co-therapists A and B were students in training. S. was welcomed by A. who then asked the group to explain to S. the purpose of the group. He was told that they were there to share their feelings and experiences with each other. He was asked if he would like to share something of himself with the group. He stated that he had been referred for drug abuse and that he had not been getting along with his father and had a lot of anger towards him.

A short while later in the meeting, the topic of conversation was angry feelings. Two members who had been in the group for some time had been holding the floor on this issue. B., the second co-therapist, attempted to involve the rest of the group by stating that she wondered whether other group members got angry and how they dealt with their anger. In her process record B. reported:

> S. said that he is still angry with his father. In fact he feels like killing his father, throttling him to death. He said that he becomes physically violent when he is angry. He related incidents of how he throttled two children at school because they used to tease him by telling him he is nothing, worthless, lazy. He also throttled his cousin who treated him as anothing in life. He wants to throttle his father and to watch him dying eventually. His father has treated him as nothing since his childhood. (6)

S. was then asked by A. if he would like to throttle his father

* therapeutic

in the group. He agreed and A. fetched a cushion which he handed to S. who proceeded to kill his father symbolically. He was given positive feedback by the two therapists who told him that he had 'worked' well in group. It did not surprise the writer to hear that S. had assaulted a member of staff three weeks later.

Although A was not one of the writer's students she was able to use this incident to teach the importance of diagnosis to the psychiatric social work students in a group supervision session.

Without any background information it was still clear that S. could not be diagnosed clinically as a neurotic with a great deal of repressed anger creating intrapsychic stress. He had no difficulty expressing his anger right from the start of his therapeutic experience nor did he manifest great anxiety or guilt about his anger. His difficulty lay in containing his anger and his habitual method of dealing with it was to act out violently. From this evidence alone his nosological diagnosis was more appropriately placed in the category of character disorders. Therefore,an intervention technique designed to bring about carthasis through the expression of repressed anger, appropriate in dealing with a neurotic patient, was totally inappropriate in this case.

In supervision discussion the students were also able to pick up that use of this technique was equally inappropriate for a patient in his orientation phase in the group. He had not yet learnt to conceptualize psychologically so was more likely to see this technique as sanctioning his violent behaviour than as a means of releasing pent-up anger. He still had to learn the group culture that feelings need to be recognized and accepted but that

maladaptive behavioural modes of expressing these feelings need to be controlled and more adaptive patterns learnt. As a new member of the group his need was for the acceptance and approval of both therapists and his fellow group members (siblings). The approval given by the therapists must have reinforced a conviction that violent response to anger was socially acceptable behaviour to an even greater degree.

This example highlights the hazards of gaining a theoretical beackground of technical skills but no concomitant diagnostic understanding.

Placing students in open groups that have no clear beginning or end phases exposes them to group processes at their most complex as this excerpt from a student's Final Evaluation report demonstrates.

> I moved into a group in two stages - termination feelings re M's (therapist) going and also G's impending termination being worked through; causing G and L to do some real work. Simultaneously half the group was in an orientation stage and not being able to work on the same phase, withdrew.
> In group two (i.e. the second meeting) there is active testing out and insecurity about being able to trust me and anger at all the changes. O and D both expressing suicidal feelings which is a very indirect way of expressing anger. There is also some scapegoating of S and L and demands being made on them to reveal themselves. G is feeling she is not good enough or well enough to leave. L feels we don't care so why should he reveal himself. If therapists cared they would not leave the group nor would they discharge patients. At the end of the group D is concerned that his hostile feelings may have hurt W (co-therapist) and he projects anger onto W, asking if the latter is angry with him. (7)

This description of two meetings emphasizes some of the complexities. Thus, O, D and S were all relatively new members. They were in the orientation phase and were testing out the therapists

to see if they could trust them and if the therapists would be all-caring parenting figures. G and L were working on issues of termination and separation. This called for a variety of different interventive responses from the therapists, and a considerable degree of diagnostic skill.

As the group meetings in the therapeutic milieus are held four times a week, group development and movement take place so fast that it is difficult for trainees to stand back from the experience in order to analyse what is happening and to modify intervention where needed. Thus, where there is little theoretical background and no regular supervision diagnostic assessment becomes a lost art and incorrect interventive patterns can be perpetuated instead of corrected.

These examples provide cogent evidence that the stress laid by writers, such as Johnson (1963), Yalom (1975) and Walton et al (1971), on the importance of well-organized group psychotherapy training programmes which include inter alia close intensive supervision is well founded. Yalom, in particular, points out the folly of basing training programmes purely on an individual model and expecting students to somehow translate individual therapy training into group therapy skills.

6. The Need for Common Training

The previous section provides evidence for the need for some common training as well as improved training. Many of the difficulties in the sessions outlined in the first example arose because of the co-therapists' different outlooks and opinions with regard to the way the group should be conducted.

The use of co-therapy is a debatable issue. In the writer's opinion co-therapy can be extremely effective if the two therapists have already developed skill in both diagnosis and intervention. They can split roles, one being provocative and the other supportive. They can switch these roles too. Combined support and confrontation can often overcome the resistance of patients to look at maladaptive ways of behaving. To use this technique effectively the therapists must be able to communicate with each other from within a common theoretical framework and they should also be in tune with each other and sensitive to each other's responses and reactions. As Yalom (1975) says, co-therapists must be comfortable with each other.

There are a number of positive factors attached to the use of co-therapists. As Johnson (1963) points out the anxiety level of a group therapist is at a much higher level than it is in other forms of therapy. A novice therapist's anxiety can be contained if he/she goes into his/her first group therapy experience with an experienced co-therapist. He/she has the security of knowing that there is someone who can deal with issues and crises that he/she, the novice, would not yet have the necessary skills to handle. It is very difficult for the beginning therapist to cope with hostile testing out, group anger, or massive group pressure on a member to act in a harmful way.

The experienced therapist also provides a model for the learner therapist and can give useful feedback to the learner after a session.

In psychodynamic terms the group is visualized as a recreation

of the primary group, i.e. the family. Having two therapists creates a more normal family setting. A male and female partnership has decided advantages in this respect.

Another point made by Johnson (1963) is that co-therapists can aid the group process by increasing the group interaction.

There are many negative factors as well. Modelling is beneficial when the learner picks up skills from the experienced therapist but is negative when that therapist makes blunders that are not picked up in supervision or feedback sessions. These, then, can be internalized by the learner as part of an acceptable repertoire of interventions. When the more experienced therapist is, in fact, relatively inexperienced he/she is even more likely to make mistakes.

Yalom (1975) is of the opinion that the status differential caused by a learner working with an experienced leader often results in tension and unclarity about the leadership role for both therapists and patients. He also points out that when co-leaders are uncomfortable with each other, are closed, competitive, in wide disagreement about style and strategy, there is little likelihood that their group can develop into an effective working group. This is corroborated by the writer's evidence in the previous section.

Splitting is a common group phenomenon occurring in groups led by co-therapists. Patients will attempt to split the therapists in much the same way they may have attempted to split their parents in childhood. Patients often seem to have a built-in radar system and are able to home in unerringly onto therapists' vulnerabilities. So they will soon pick up on tensions in the

relationships between therapists. This can become very destructive, can split groups and prevent cohesion from taking place.

Difficulties in co-therapist relationships become magnified when the therapists stem from different disciplines and there is no common supervision. The therapists come from a background of differing professional value systems and often different theoretical approaches. There is frequently conscious or unconscious inter-disciplinary competitiveness.

The writer has found that in her supervisory sessions with students an inordinate amount of time and energy needs to be spent on difficulties caused by working with a co-therapist. She has also found that frequent changes of co-therapists have a disturbing and unsettling effect on students. Of course if a co-therapy relationship has been poor a change comes as a relief. The fact remains that an enormous amount of energy is spent on learning to work with and adapt to an assortment of co-therapists most of whom start off as an unknown quantity to the students.

The writer feels strongly that, if trainees and group members are to reap the benefits of co-therapy rather than become bogged down by the negative factors, some common training and supervision needs to be instituted.

PART II

An Analysis of Training Requirements for Practitioners of Group Therapy in Therapeutic Milieus

1. INTRODUCTION

In their chapter on training requirements for group pshyco-therapists Walton et al (1971) specify three necessary components, viz.:-

a) Acquiring a system of theoretical knowledge about group processes. They suggest that this can be obtained through lectures, seminars, reading, group discussion, and observation of more experienced colleagues at work.

b) Actually carrying out the activity, in other words, in order to learn how to conduct a group the trainee must actually conduct a group.

c) Close and regular supervision.

They also suggest that the experience of being oneself a patient in a therapeutic group is a useful training adjunct. This writer feels that being a member of an experiential group is sufficiently important for attendance of an experiential group to be accepted as a fourth essential training requirement. She feels that the basic requirement of any therapeutic endeavour is the use of relationship, in other words, before any attention is paid to the development of a complex host of techniques and interventive skills it is important to consider the therapist's capacity to establish warm, caring relationships with patients. As Yalom says:

> Underlying all considerations of technique there must be a consistent positive relationship between therapist and patient. The basic posture of the therapist to his patient must be one of concern, acceptance, genuineness, and empathy. Nothing, no technical consideration takes precedence over this. (8)

In other words, the therapist's basic tool is his/her own self. It might appear from this, that the most vital factor of successful therapy is a built-in given viz. a therapeutic personality. To a certain extent this is correct. However, any supervisor will point to evidence that relationship skills can be developed during training. These skills are acquired through the development of theoreti al constructs that help the trainee understand the patient and his functioning; through practice and supervision. However, to develop use of self to its maximum potential therapists must develop as much self-awareness as possible, i.e. acquire a degree of understanding of their own personality and habitual behaviour patterns. This is, of course, why individual psychotherapy is either a requirement or a recommendation for all trainee therapists. For group therapists attending an experiential group helps development, not only of intrapsychic insight, but of insight into their habitual patterns of relating to other people and their reactions and responses to group processes. In addition experiencing the impact of group forces as members of a group rather than as leaders helps them develop their capacity to react with empathy to their own patients.

This writer will, therefore, consider training requirements for the practice of group therapy in the therapeutic milieus in terms of four components, viz. 1) A theoretical foundation; 2) Attending an Experiential Group; 3) Practice of Group Therapy; 4) Supervision.

2. A Theoretical Foundation

In this section the writer will outline the theoretical

foundation which she feels should form the basis of the theory course on group therapy in the Clinical Social Work Master's degree programme. She will propose that this outline serve as a basis for consideration and critical evaluation of all the psychiatric disciplines with a view to formulating a common theoretical training programme in group therapy.

A. The Psycho-Social Model

The overall theoretical model proposed by the writer is a psycho-social one. The psycho-social model which has grown out of the professional practice of social work was originally formulated by F. Hollis in her book Casework - A Psychosocial Therapy published in 1964. This model could in fact provide guidelines for an overall theoretical framework for treatment planning and implementation in the therapeutic milieu functioning as a whole. The psychosocial model has drawn on and integrated both the psychoanalytic and systems models which were mentioned by Dr Kernberg as the basis for therapeutic milieu functioning and which are used today in the therapeutic milieu placements.

The Psychosocial model is seen as

> an open system of thought, evolving and changing as new knowledge and demonstrations of practice modify or enrich earlier formulations. (9)

When the focus is on work with groups the model draws its theoretical strands from psychoanalytically oriented ego psychology, developmental theory which originated from the work of Erikson and Piaget; social systems theory, role theory, communication theory, behaviour modification and above all, small group theory.

Northen in Roberts and Northen (1976) sees the goals of social groupwork as lying within the realm of enhanced psychosocial functioning.

> Psychosocial functioning is concerned with the complex gestalt of emotion, cognition and action, motivated by both conscious and unconscious forces in the personalities and the persons involved and the resulting patterns of relationships between people in defined situations. It may be desirable to increase the adaptive skills of the ego, to improve the functioning of the system in which the difficulty lies or frequently both. The hoped for change may be in the individual's attitudes, emotions and behaviour, in the group structure or process, in the environmental situation or most commonly in the interactions involving person-group situation. Thus the integrating idea is the dynamic interplay between person, group and situation. (10)

It is of course important to distinguish between social groupwork and group therapy. The parameters of group therapy are much narrower than those of social groupwork which covers a broader spectrum of group activity and methods of running groups. Nevertheless, the wealth of literature and practice wisdom that stem from the field of social groupwork can offer a great deal that can be of benefit to the trainee group therapist.

B. The Remedial Model

A number of social groupwork practice models have been identified over the past two decades. Papell & Rothman (1966) were the pioneers in this field. Although none of the models are sufficiently comprehensive to stand as distinct theoretical entities they provide useful conceptual frameworks for the analysis of practice, and, therefore, a useful starting point in a theory course. Two of Papell & Rothman's models are of interest, viz.

the Reciprocal or Mediating model and the Remedial Model (sometimes referred to as the Treatment Model). The former is useful for any work in which systems theory is used as it conceptualizes the function of the worker as a mediator between systems and subsystems. This model is of interest for work in the therapeutic milieus as a whole. However, as the focus of this paper is on training for the group therapy component only, the Remedial model is the relevant model to outline.

As group therapy is a treatment process it falls into the orbit of this model which is a clinical model focussed on 'helping the malperforming individual achieve a more desirable state of social functioning'(11)

The group is viewed as a tool for the treatment of the individual and stress is laid on the formulation of diagnostic goals for each individual member by the worker. These individual goals supersede group goals. Thus Papell and Rothman state:

> Changes in group structure and group process are the means to the end goal of individual change ..... Processes within the group which help members to help each other are given recognition in this model but the limit of the self help plan is contained within the boundaries of the diagnostic plan. (12)

They view the role of the worker as

> a change agent .... sequentially phasing his activities in the tradition of study, diagnosis and treatment. .... He is characteristically directive and assumes a position of clinical pre-eminence and authority. (13)

They see the central and most powerful concept as the treatment goal. Specific goals must be established for each individual member and group purposes are defined so that they are

consistent with these individual goals. The worker thus helps the group develop a system of norms and values which are in accord with the treatment goals which he has formulated. Ideally treatment goals will be formulated together with group members but this is not always the case.

Churchill in Glasser, Sarri & Vinter (1974) points out that there are two major sets of theoretical and empirical knowledge incorporated in this mode, viz:-

a) conceptualization of an individual and of individual behavioural change

b) conceptualization of group processes and group structures.

The study of individual dynamics and behaviour is a separate course in its own right in any clinical training programme. It is assumed, therefore, that this need not be duplicated in a group therapy course. However, in her chapter on Psychosocial Practice in Small Groups in Theories of Social Work with Groups edited by Roberts & Northen (1979), Northen provides an excellent psychosocial definition of the individual which the writer feels should provide the base for viewing the individual within the framework of groupwork and group therapy practice.

> The person is regarded as a constantly developing being in necessary and significant interaction with others. He is a biopsychosocial entity - a whole person and he is also a component of a network of social systems. His behaviour is purposive and motivated by both conscious and unconscious forces. His attitudes and behaviour are understood in terms of his unique attributes, his idiosyncratic perceptions of self, others and situations and the particular meanings that experiences have for him as these are evidenced in specific situation. (14)

C. Group Dynamics and Processes

Conceptualizing and understanding both group processes and group dynamics is an essential feature of a course on group therapy.

The term group dynamics has been used in a variety of ways and is often used interchangeably with the term group processes. Douglas (1979) points out that the essential feature is that group dynamics is the study of groups as entities existing in their own right. As he comments, group dynamics is a complex multi-dimensional study. Such study is clearly beyond the scope of a short group therapy course. However, it is important to conceptualize the group as an entity existing in its own right and to have an understanding of some of the processes involved.

Douglas in his book Group Processes in Social Work - A Theoretical Synthesis (1979), has provided the most comprehensive analysis of group processes to date. Processes are seen as the dynamic and distinctive properties of a group. He has classified group processes as follows:

Category I	Basic	INTERACTION
Category 2	Structural	Group development Social Structure Subgroup formation
Category 3	Locomotive	Purpose and goal formation Decision making
Category 4	Molar	Norms, standards, values Cohesion Group Pressure influence Climate

> INTERACTION is absolutely fundamental in that without it no group or process exists. Thus INTERACTION is an integral part, i.e. a generative factor in all the other identified processes. (15)

He sees the structural processes as instrumental in effecting change in the group which is regarded as a discrete entity or as a system. The locomotive processes are those factors which create and 'move' a group towards its operational ends so are in a sense directly and indirectly concerned with outcomes. Molar processes are seen as containing large elements of emotional response and are not structural but affect structural processes, interaction and locomotion in a variety of ways.

a) Group Development

In this writer's opinion one of the most important concepts is that of Group development. Sarri and Galinsky (1974) define group development as 'changes through time in the internal structures, processes and culture of the group'.(16) They point out that practitioners who seek systematic control of and change in group conditions to attain treatment goals need to understand what group development is. The writer finds the Life Cycle Model of group development postulated by Northen (1969) most useful for diagnostic understanding of group development. Johnson (1963) and Yalom (1975) use a simplified version of this model.

The phases or stages conceptualized are simple, easily understood and recognized.

Northen (1969) outlined the following five stages of group development:- 1) Planning and Intake; 2) Orientation Stage;

3) Exploring and Testing the Group; 4) The Group as a Problem-solving medium; 5) The Termination Stage.

Johnson (1963) only talks of three stages. Stage one is seen as the formation of a working relationship. This stage is the equivalent of Northen's orientation stage. Stage two is seen as a transitional phase that is characterized by the group members' ventilation and recognition of hostile feelings to the group therapist and the development of the group identity. This is the equivalent of Northen's testing out phase. Stage three is defined as the period of group mutual analysis and is the equivalent of Northern's fourth stage.

Planning and Intake. Under this rubric the clinical social work students need to study the issues of selection criteria, group composition and contracting with group members prior to the start of the group. This study should consist, by and large, of revision as these issues are covered in undergraduate training. However, selection for group therapy requires an understanding of clinical issues with regard to working with neurotics, psychotics and personality disorders. In this respect the students can be expected to consult inter alia the work of Slavson (1943), Johnson (1963) and Yalom (1975). Johnson's chapter on use of the Group Contract in group therapy is also recommended.

These issues are not really applicable to any great extent in the therapeutic milieus. However, some knowledge of selection criteria would seem important. The literature abounds with contradictions with regard to selection criteria. For therapeutic milieu purposes exclusion criteria seem more pertinent

than those for inclusion. Yalom's (1975) chapter on The Selection of Patients is suitable reading in this respect.

The literature does however provide evidence that within several stages of the life cycle differences in age influence group participation. This is obviously more important in childhood and adolescence than in adulthood. Johnson (1963) believes an adult group can contain an age range of between 21 and 50 years. For adolescent groups however there should be a far narrower age range. Students are referred to Berkovitz's book Adolescents Grow in Groups (1972) if they are to run adolescent groups. Placing adolescents and adults in the same group is contraindicated.

Orientation. The initial phase of any group is almost always characterized by anxiety and ambivalence towards the unknown situation. There is dependency on the leader who is the central focal point and the group is preoccupied with issues of acceptance and approval. As Johnson (1963) states

> Nearly every member enters the group with the hope that the therapist will like him (or her) best and provide some type of magical solution for his problems. He is not concerned with the other members of the group. (17)

In this stage issues of trust are prevalent. Until trust develops members cannot participate in interdependent relationships with others. It can thus be seen, that at this stage, the worker needs to help the group begin to bond by using supportive techniques, helping the group clarify the purpose of the group and by developing caring norms.

Orientation phases occur even in open groups when there is a change of therapists and when new members enter the group.

Exploring and Testing the Group. Yalom (1972) describes the preoccupation with dominance, control and power in this phase. Thus, characteristic conflict is between members or between members and leader. The emergence of hostility towards the therapist is an inevitable occurrence in the life sequence of the group. It arises largely out of the group members' unrealistic expectations of the leader and the gradual recognition that they will not be the best beloved child of the therapist. This is not a clearly conscious process nor is it constant across groups in form or degree. Degree of hostility and the form it will take is greatly influenced by the behaviour and personality of the therapist.

It is very important for trainee therapists to recognize and understand this stage as it can often be difficult and unpleasant to live through. If this hostility is suppressed either consciously or unconsciously group development is retarded. The trainee therapist needs to recognize, acknowledge and accept the hostility.

Northen (1969) points out that there are positive aspects to this stage too.

> These include exploration of the interpersonal potential in the group, working toward emotional integration, creating exchange, or a period of organization. As conflicts are resolved, the satisfaction of the members is enhanced and the members are freed to work together on other problems which further the group's transition into the next stage. (18)

The Working Phase. This stage is characterized by cohesiveness.

> A group in which members accept and are interdependent on others has emerged. This stage is characterized by the interdpendence of the members in sustained work on problems in personal and social functioning which are related to the goals of the members. (19)

In this phase the therapist will use interventive techniques that help push the patients towards change and growth.

Of course conflict continues to be present and serves as a dynamic for change.

W. Schutz's (1958) Recurrent Cycle Model is another model that is helpful in looking at this stage in more detail. He postulates that groups tend to regress especially in times of crisis and that there are various focal issues to which the group returns again and again, each time at a higher level.

Thus the stages of development are not clear cut. Testing out certainly continues and re-occurs at intervals. Nevertheless developmental models retain the belief that the group grows out of each stage in sequence.

If interventive techniques are used that are inappropriate to the stage of the group they are likely to be ineffective.

Termination. Although this stage is not mentioned as such by Johnson (1963) and Yalom (1975) this writer feels that recognition of the characteristics of this final stage is absolutely essential and that appropriate handling of termination is of the utmost importance. The process of termination reactivates all the past unresolved separation conflicts in group members. Through

learning about and working through termination in the group they can start coming to terms with the painful and difficult issue of separation. The impact of termination is of course seen at its most dramatic and powerful when the group as a whole is terminating. But it is still evident in open groups when therapists and members leave the group even if only to move on to the next group.

In the writer's opinion W. Schwartz gives one of the best descriptions of the phases of the termination stage in his chapter in Roberts and Northen (1976).

> There is an evasive period in which the prospect of ending the group is ignored or denied. There is a sullen angry stage in which the worker finds himself back in the beginning aspects of the relationship, resisted and suspected. There is a period of mourning in which the members are close to their complex feelings about the worker and the others in the group and are capable of intensive work on the meaning to them of the experience. Finally if there is time and skill in dealing with the mourning period, there is a kind of graduation effect — the future is regarded with optimism, there is a tendency to reject the worker and there is considerable rehearsing for new stages of experience. (20)

It is very important to help group members look at and accept the feelings associated with termination. This is not, however, enough. Termination should form part of the serious work of the group. They need to look at what is happening to them and learn from this and they should use this final stage as an opportunity to articulate gains that have been made and goals for the future.

b) Psychoanalytic concepts of group dynamics

As the *milieus operate within a psychodynamic framework it

* therapeutic

is also important to look at some of the concepts of group dynamics that stem from psychoanalytic theorists.

Bion (1961) was the leading exponent in this field. His influence has been considerable in terms of his method of viewing the group as a whole and his attempts to understand the unconscious forces influencing the group. His concepts are not easy to grasp so the writer would not include his book as a basic prescribed text. However, it should be recommended as additional reading in a course on group therapy, and students should be made aware of histwo most important concepts, viz i) the working group and ii) basic assumptions.

(i) The Working Group. He sees the primary task of the group as the exploration of its own intragroup tensions. He considers that there are always attempts by the group members to provide structure in the group in order to hold the group to a rational level of behaviour which is suitable to fulfilling the conscious aims of individuals. Thus in the work group there should be a common purpose; common recognition by members of the group's boundaries and its position and function in relation to other groups; capacity to absorb new members and to lose members; recognition of the value of a subgroup to the main group but also that internal subgroups should not have rigid boundaries; a capacity to face discontent within the group and have a means to cope with it. Ever member of the group should be valued for his contribution to the group and should have free movement within it.

ii) Basic Assumptions. Bion postulates that there are times when a group does not pursue its primary task. At these times it appears to be dominated by massive emotional states which

result in behaviour that is incompatible with its primary task. He postulates that there are three basic recurring emotional states, all centering around the issue of leadership in a group. In each of these states members act as if they shared some common belief from which their emotion stems. These states need not be conscious to the group. Bion refers to them as basic assumptions.

i) The first basic assumption concerns dependence. The group acts as if it needs to preserve itself by obtaining support from the professional leader. The members attempt to coax or coerce the leader into providing guidance. The prevalent feelings in the group are helplessness and/or awe.

ii) The second basic assumption concerns pairing. The group acts as if it needs to preserve itself by finding strength in a new leader. Pairing of members occurs. The group hopefully anticipates the emergence of a new leader from this pairing.

iii) The third basic assumption centers around fight/flight. The group acts as if it needs to preserve itself in the face of some danger and that this can only be done by fighting or running away. There is a search for a leader who will lead the group into fight or flight. The prevalent feelings are aggressiveness, hostility and fear.

The therapist will become aware of basic assumption behaviour when he/she observes behaviour that seems illogical and disconnected as if the group needs to act in one of the three

abovementioned ways.

Bion does not hypothesize any stages of group development. G. Bach, who developed a more elaborate system of group development than the one presented in this paper is quoted by Foulkes and Anthony (1972) as suggesting that Bion's 'basic assumptions' and 'work' groups might fit into his developmental scheme if 'one could imagine the 'assumptions' evolving steadily from dependency, through pairing and fighting and fleeing to work'(21).

This writer prefers the concepts used by Foulkes and Anthony (1972) to delineate conscious and unconscious forces within a group. They refer to manifest and latent levels. Manifest content would be the conscious content of group discussion. On the latent level the group may be seen as a recreation of the primary family group. Thus multiple transference reactions will occur between group members and leaders and members and members and these result in the latent processes of group functioning.

Foulkes and Anthony postulate that four basic conflicts are played out in group psychotherapy, viz. conflicts over conformity, authority, dependency and change.
They see all these conflicts as different aspects of an overall conflict over dominance in the basic sense of the parents' dominance over the child. This is the primary conflict of man as a group animal.

i) Conformity. Foulkes and Anthony state that the individual in any group must behave himself according to the standards imposed by the group. However, in every person there remains a narcissistic, egocentric core - the 'self'. Conflict occurs

betwen the need of the self to express individuality and the need to conform to the norms of the group.

ii) Authority. The second conflict theme concerns reactions to authority and authority figures. Conflicts in this area are played out from the beginning stages of the group within the group members' relationships with the therapist. Feelings for the therapist, as for the father in the past, are ambivalent - good feelings and love being counterbalanced by hostility.

iii) Dependency. The third conflict theme centers around the problem of dependency. As Foulkes and Anthony point out group development is similar in many respects to child development. As the parent needs to guide the child towards increasingly autonomous functioning so does the group therapist.

> The child is expected to mature beyond his childish belief in the omnipotent parent. He must learn to stand on his own two feet and dig in his own ten toes when the need arises. He should not eventually wish to dominate or be dominated, crawl before authority or remain everlastingly resentful and rebellious towards it. (22)

Developmentally the form of the dependency conflict varies with the age of the individual from the stage of intra-uterine dependency, through the stages of breast dependency and parent dependency. The classic conflict between the needs for dependency and the needs for independency is waged in the adolescent developmental stage. It is usually the picture of this conflict theme that is seen in a psychotherapeutic group. But Foulkes and Anthony believe that all seemingly adult conflicts about dependency are reactivations of infantile ones.

iv) The fourth conflict is the conflict over change. Change

is implicit in therapeutic treatment. Foulkes and Anthony suggest that one of the classic resistances of any patient or group is the resistance to change either in themselves or their environment, in other words a patient's wish for help is ambivalent and to a large degree he/she comes not to be changed but to be approved of. Within the group there will, therefore, be resistance to all group changes; members and therapists leaving, new members coming, changing seats or times of meetings and above all any group developments into new and unfamiliar psychological territory. It is, therefore, very important for the therapists and group members to be able to observe signs of change. Real change is not overtly dramatic but occurs in terms of small inner changes.

Foulks and Anthony do not feel that clear cut stages of group development exist but suggest that characteristic themes centering around these four conflicts develop temporarily in a group in the form of manifest and latent movements.

This writer feels that these formulations can be used in conjunction with the life cycle model of group development that has been outlined. They certainly fit into Schutz's conceptualization of focal issues to which the group returns, each time at a higher level. Schutz's Recurrent Cycle model can be subsumed into the Life Cycle Model.

The preceding three subsections provide, what the writer considers are the basic conceptual tools for diagnosis and treatment/intervention planning in therapy groups.

D. Diagnostic Assessment

Implicit in both the psychosocial and remedial models is the need for diagnostic assessment. Intervention is seen as purposeful. In any form of therapy there must be a diagnostic evaluation and planning with regard to goals and method of treatment. In group therapy diagnostic assessment must embrace both the individual patient and the group processes.

Diagnosis of individual patients in the therapeutic milieu is formulated in terms of the medical model. When each patient is admitted a full psychiatrict history is taken and a psychodynamic formulation and clinical diagnosis is made. The clinical diagnosis is a nosological diagnosis based on either the D.S.M. or I.C.D. classification systems. Students learn how to take a history and make a diagnosis in their Psychiatry course. Nosological diagnosis is not very helpful in intervention planning in group therapy. However if the broad categories of neurosis, psychosis and personality disorders are understood in psychodynamic terms use of these labels does provide broad guidelines as to the type of interventive planning required. In order to visualize the individual diagnostically in psychodynamic terms this writer finds the diagram taught to her by Dr. Jim Stricklin very helpful, so always uses it in her teaching and supervison. (See Figure I).

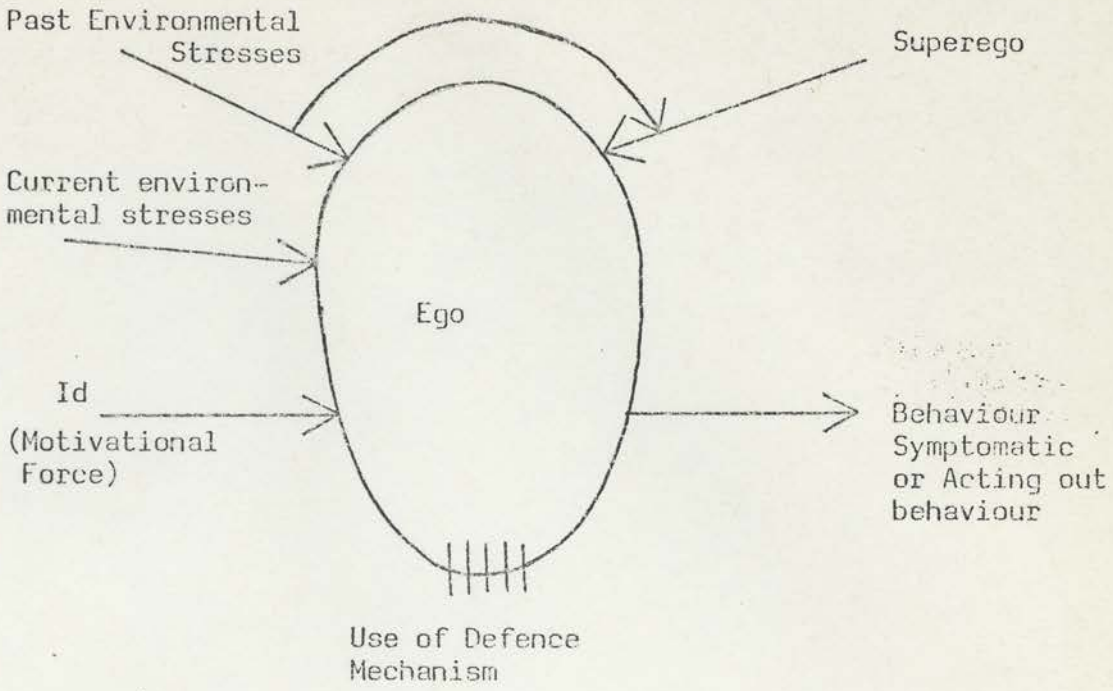


Figure I

The Id is the force that propels the individual into action (behaviour). This force is processed en route by the Ego. The Ego has to contend with three major forces impinging on it, viz. the Id, the Superego, and environmental stresses (both past and present). The resultant behaviour is dependent on the strength of these three forces and the Ego's own strength or capacity to deal with them.

In the neurotic, repression is used to deal with the Id forces and the immature Ego needs a further battery of defence mechanisms to maintain repression. The neurotic also has a punitive Superego. These warring forces result in intrapsychic conflict and when this becomes too great for the Ego to handle symptomatic behaviour occurs.

In the psychotic, who also usually has a punitive Superego, the Ego is so fragile it sometimes shatters and is unable to control the force of the Id impulses from breaking through.

In the personality disorders (other than the Anankastic personality) the Ego is immature and the patient exhibits behaviour which is impulsive, i.e. there is poor control of Id impulses, and the personality is relatively guilt-free. This leads to conflicts in interaction with other people (environmental forces) rather than to intrapsychic conflict.

Different patterns of therapeutic intervention are thus needed. For patients suffering from neurotic disorders relief from intrapsychic conflict may be obtained from the release of repressed affect and from gaining insight into past conflicts and defensive patterns. As psychotic conditions are characterized by a very high anxiety level and very fragile Ego functioning techniques to increase repression of instinctual material and for the building up of adaptive defence mechanisms would be considered. As Otto Pollak (1968) points out dealing with personality disordered patients calls for the use of very different types of intervention planning and techniques than those used for neurotic patients. This type of personality needs binding instead of liberation, restriction of behaviour in place of maladaptive spontaneity, motivation to interact with others in a giving rather than exploiting way.

For more personalized diagnosis and intervention planning the psychodynamic diagnostic formulation is likely to be of greater help.

The writer also finds Stricklin's (1974) work of use in diagnostic formulation. He formulated a developmental, dynamic, diagnostic statement which comprises five areas of diagnostic significance:- Organic factors; Intellectual/Cognitive factors; Basic Personality; Current Ego Functioning, Environmental Factors both past and present. (For further details of these areas see Appendix I).

The Basic Personality comprises the habitual modes of behaving and responding. If these are maladaptive personality disorder results. In Current Ego Functioning focus is on how the individual is reacting to the stress or problem at the present time. In this area the diagnostician will consider inter alia: use of consciousness; impulse control; ability to perceive reality, awareness of self and of actions; current relationships; motivation; use of defence mechanisms. Neurotic and psychotic conditions fall into the category of Current Ego Functioning.

It is particularly important for students to understand the factors involved in these two categories of basic personality and current ego functioning. Diagnostic assessment should be an ongoing process and students need to learn to diagnose from observation of the interaction and communication of patients in the group. They should be able to pick up both habitual modes of responding and current ego functioning in this way.

Diagnosis in terms of group development and group processes should also be an ongoing process. The students need to learn to recognize the stages of group development (even when there are elements of a number of different stages in one particular

session) and group processes such as flight, subgrouping and scapegoating. The most important tool in this diagnostic assessment is the recognition of group themes. These themes may be both manifest or latent. There may be one or a number of themes in each group session. Some of these themes are short-lived but others thread their way throughout all the sessions and reoccur with ever deeper meaning.

Johnson (1963) states that it is very important that the therapist be in control of the group. He points out that this is not done by taking over the group and discussing a subject or providing a lecture. It is done by the understanding of group dynamics through recognition of the theme of the meeting. When this occurs the therapist is able to direct the group by helping members explore this theme. When a therapist is unable to pick up the theme the group flounders and jumping from topic to topic occurs.

Skill in immediate diagnosis of process and behaviour during a group session is a skill that can only be developed through actual practice. As there are a multitude of stimuli in any one group meeting on the spot diagnosis is insufficient. Diagnostic assessment, formulation of individual and group goals and overall intervention planning needs to be done by the therapists before or after actual group meetings. Initially this is done with supervisory help and then autonomously through discussion in staff meetings and ward rounds.

In the theory course students need to gain a knowledge and understanding of the tools of diagnosis. Application skills are then learned in practice and through supervision.

E. The Role and Techniques of the Therapist

In the research inquiry into encounter group experience undertaken by Lieberman, Yalom and Miles in 1973, a major intent was to investigate the effect of leader technique upon outcome. They thus employed expert leaders from several ideological schools to run the groups in their study. They found that the ideological school to which the leader belonged told them little about the actual behaviour of the leader. Nevertheless, the effectiveness of the group was, in a large part, a function of the leader's behaviour.

As a result they undertook a factor analysis of a large number of leader behaviour variables. This resulted in the formulation of four basic leadership functions.

1) Emotional Stimulation (challenging, confronting activity;intrusive modelling by personal risk-taking and high self-disclosure).

2) Caring (offering support, affection, praise, protection, warmth, acceptance, genuineness, concern).

3) Meaning Attribution (explaining, clarifying, interpreting, providing a cognitive framework for change; translating feelings and experiences into ideas).

4) Executive Function (setting limits, rules, norms, goals, managing time; pacing, stopping, interceding, suggesting procedures). (23)

Lieberman et al found that these four functions have a clear and striking relationship to outcome as follows:

> Caring and Meaning Attribution have a linear relationship to positive outcome. The higher the caring and the higher the meaning attribution, the higher the positive outcome.

> The other two functions, Emotional Stimulation and Executive Function, have a curvilinear relationship to outcome - the rule of the golden mean: too much or too little of the leader behaviours results in lower positive outcome. (24)

The conclusion reached was that the most successful leader was one high in caring and meaning attribution but, although both these variables were critical, neither alone was sufficient to ensure success. Thus the leader also needed to display a moderate amount of emotional stimulation and executive function as well.

These four factors should form the four parameters within which the trainee therapist learns to visualize his role (how he must be in the group) and develop his techniques (what he must do in the group).

The writer sees the development of the student in terms of three interlocking phases,viz. the development of relationship skills (these center around how he/she must be in the group); the development of skills in diagnosis, goal setting and intervention planning (discussed in the previous section) and finally development of intervention strategies and techniques (what he must do in the group). In the final instance he develops his own personal style.

It is well known from the literature that most group therapists develop their own style which is not dependent upon the ideological framework within which they are trained. Trainee therapists can nevertheless benefit and learn a great deal from the theoretical and practice wisdom of experts. This is found in a number of excellent texts on the practice of group therapy.

As group therapists in the therapeutic milieus operate within a medical model with an overall psychodynamic framework, they need to develop an operational style that is congruent with this.

With this in mind the writer selected three basic texts for the study and the role and techniques of the therapist in her group therapy course, for the Clinical Social Work Master's programme, viz.

a) S.H. Foulkes and E.J. Anthony - Group Psychotherapy - the Psychoanalytic Approach

b) J. Johnson - Group Therapy (he uses what he calls an Adaptional Model or Approach)

c) I. Yalom - The Theory and Practice of Group Psychotherapy (he uses an Interactional Model or Approach).

All these texts deal mainly with work with adult patients. As the therapeutic milieu patients are adults or late adolescents the writer does not include work with adolescents and children in this section of the course.

She also included the work of two humanist-existential practitioners, viz. Carl Rogers and Fritz Perls. She felt that they had developed concepts and techniques that could be adapted and modified for use in a psycho-social model. Her aim was to provide students with an eclectic approach to aid flexible practice.

As her course was time-limited choice was circumscribed. She thus chose to use the work of Foulkes and Anthony rather than that of Slavson to represent the psychoanalytic approach. This is perhaps a debatable choice. Ideally both should be studied.

Douglas (1979) points out that psychoanalytic group leaders

Douglas (1979) points out that psychoanalytic group leaders are not by any means unified in their use of basic concepts that there is a fundamental dichotomy between those like A. Wolf and Slavson who see the group as a milieu for the psychoanalysis of the individual and those who see the group as a therapeutic agency.

Slavson (1943-1960) sees transference as the major dynamic in all forms of psychotherapy. Thus emotional transference to the group leader or other group members will highlight latent motivation and reveal hidden pathology. He postulates that transference in groups occurs in cycles and sees the expression of hostility towards the therapist in transference as being the primary requirement in psychotherapy. Latent hostile and aggressive feeling towards the parental figures is seen as being always near the surface and easily activated. The expression of hostile feelings is greatly facilitated in group therapy because of the support patients give each other. If this negative transference does not occur there is resistance in the patients. However negative transference is seen as transitory. Basic transference must be positive before it can be used as a treatment tool.

He sees the role of the therapist as a passive role and he is one of the writers who talks of the importance of the possession of a therapeutic personality. He believes that some therapists have qualities better able to evoke responses, encourage positive transference and promote improvement than others. Interpretation is only used when the emotional setting is appropriate, suspicion and distrust have worn off and positive transference

established.

Foulkes and Anthony, Johnson and Yalom all retain his conceptualization of the development of transference both negative and positive.

However, Slavson does not believe that the dynamics in ordinary groups make their appearance in analytic groups. He believes that each patient must remain a detached entity in which intra-psychic changes must occur. His concept of a group is more that of a 'compresence' of patients rather than a group of patients.

The writer feels that this approach is very limiting. To her knowledge there are no practitioners in Cape Town who maintain this extreme stance. The psychoanalytic approach of Foulkes and Anthony where the individual is the focus of treatment but the group is seen as the treatment tool is preferred.

Foulkes and Anthony, Johnson and Yalom all see the group leader or authority figure as the most important or central figure in the group. They see the role as requiring professional training and skill. They all see the major task of the therapist as giving direction to the group so that it can be welded into a cohesive, therapeutically beneficial medium. They are not among the theorists who, according to Foulkes and Anthony, look upon group development as something quite autonomous once the collection of individuals has become a group. They believe that the therapist must be aware at all times of his direction of the group.

In executing this task they all recognize the prime importance

of the development of positive, sensitive and empathic relationships with the members of the group so that positive transference can occur.

a) Foulkes, S.H. and Anthony, E.J.: Group Psychotherapy. The Psychoanalytic Approach 1972.

In viewing the role of the therapist Foulkes and Anthony state that what the therapist thinks and what he feels will chiefly determine what therapeutic use the group makes of the group.

> The therapist learns to understand and treat the group and consciously (and less consciously) deploys his own feelings and reactions as therapeutic measures in the service of the group. The therapist does not express these feelings; he is merely sensitively aware of the quality, quantity and direction. He constantly matches his own reactions against those of the group, just as he matches his background in group experience, his capacity for intuition and empathy and his specialized knowledge of individual behaviour. (25)

Thus, although the therapist must have insight into his own dynamics he does not seek to reveal his own personality verbally in the group. At the same time he does not attempt to maintain the relative anonymity and passivity of the psychoanalyst. He interacts with the group and maintains a relatively realistic role. Within transference, regression is not encouraged and the transference neurosis is not fully established.

They see the guiding principles of intervention as:

i) concern with the dynamic unconscious

ii) interpretation of resistances, defence reactions and transference

iii) analysis, correction and deeper understanding of human relationships.

Concentration is on communication. Thus, through use of free floating discussion the material produced in the group, and the actions and interactions of its members are voiced, analysed, interpreted and studied by the group. The subject matter has both manifest and latent content and there is exploration of the social unconscious as well as the individual unconscious. Each individual's feelings and reactions will reflect the influences exerted on him by other members of the group and by the group as a whole.

To achieve this, frank disclosure of personal feelings and experiences and feelings towards other members of the group is encouraged and tolerated. Relaxation of censorship to allow the emergence of unconscious material is facilitated by the norm that patients say anything they think of or anything which comes to mind. Discussion is left entirely to the spontaneous mood of the group and its members. In this way the basic conflicts outlined in Section D emerge.

The resultant communication is translated and interpreted not only by the therapist but by the whole group. Thus the group are not merely recipients of treatment but are actively engaged in the therapeutic process.

b) J. Johnson - Group Therapy - A Practical Approach 1963

He views the role of the therapist within an adaptational frame of reference. The behaviour of the members during the group meeting is utilized by the therapist so that they, the members, can examine and identify their failures in adaptation. They learn that these failures are due to their faulty emergency responses to fear, anger and guilt. Once failures in adaptation have been recognized by the group members, new methods of responding can be attempted either by modifying or changing their maladaptive patterns.

He sees the general goals of the therapist as i) improving members' reality testing; aiding in their socialization; iii) fostering development of psychological aptitude i.e. the awareness of the relationship of emotional reactions to anxiety and defensive patterns of behaviour. Finally he hopes to provide an opportunity for the group members to see that their reactions and feelings in the group are similar to their reactions and feelings in other groups and that whatever emotional re-education and relearning is achieved by members in the group can also be applied to outside relationships.

The focus of the therapist is on the anxiety that develops in human group behaviour. He needs to be constantly aware of the level of anxiety in the group and needs to be able to reduce or raise this when necessary and to recognize when it is at the proper level for constructive work and mutual analysis.

Johnson also stresses that the therapist needs to be aware of his own emotional impact on the group and how this influences the behaviour of the members. He needs to be aware of the dynamics of the group and be able to retain control of the group through recognition of the themes of group meetings.

Johnson's interventive strategy emphasizes group rather than individual responses. He states that the therapist must be aware that he is doing group not individual therapy. Group therapy thus becomes an experience in social relationships whereby group members' habitual maladaptions occur in the here and now of the group meetings. The therapist needs to employ a technique that explores with the group members their behaviour patterns as they occur. When the time is ripe the therapist should also confront members

with their faulty emergency responses towards both the therapist and the other members of the group. In this way the patients develop psychological aptitude and awareness of their emotional interaction with others.

The therapist organizes the verbal content as well as non-verbal attitudes and behaviour into proper perspective for the group and comments on the various manifestations of the group dynamics such as silences and absenteeism that occur.

During the testing out period he must encourage ventilation and recognition of the defensive hostility of the members and must in particular encourage the examination and expression of feelings about himself. He should be able to allow himself to become the scapegoat for the hostility rather than allow it to be displaced onto other members. Hostile feelings are never worked through entirely and the level of anger goes up and down throughout the group's life. Like Slavson, Johnson believes that the group will be unable to reach a working phase until the initial hostility is cleared away. He also stresses that the therapist must assess his own defences at handling this hostility as well as at handling the anxiety in the group in order to free himself to deal with it therapeutically.

His technique does not neglect the past but emphasis is on the immediate present. Thus, the therapist is primarily concerned with failures in adaptation today, how they arose and what the patient must do to overcome them. Interpretation always begins and ends with the present. This applies to all behaviour including transference which is seen as reflecting a failure in current adaptation. The therapist does not make the interpretations nor

does he point out to individual members transference phenomena, anxiety or acting out behaviour. He asks the group as a whole to discuss the thoughts and feelings each members expresses and then to make the interpretations, in other words, he acts as a catalyst.

He believes that insight alone is not enough. Each member must undergo a process of emotional re-education until he/she develops new patterns of healthy behaviour to a point when these become automatic responses. It is this that is ultimately curative.

c) I. Yalom - The Theory and Practice of Group Psychotherapy 1975

Yalom feels that, before mastering any techniques it is essential for the therapist to fully understand the strategy and theoretical foundations upon which all effective techniques must rest. He, himself, is greatly influenced by the work of Harry Stack Sullivan and sees psychopathology in terms of the origins and expression in disturbed interpersonal relationships. Like Johnson, he places much greater emphasis on the value of interpersonal learning than on genetic insight (the meaningful linking of past and present based on the resolution of transference neurosis).

As far as the role of the therapist is concerned he states that initially the therapist is the group's primary unifying force. At this stage the members relate to one another through their common relationship with him. He must recognize and deter any forces which threaten group cohesiveness. His role thus involves culture building and the construction of norms. Yalom contends

that the therapist always shapes the norms; that virtually all of his early behaviour is influential. It is essential that he be aware of this otherwise this influence may be unwitting. What he does not do may be more important than what he does do. A raised eyebrow, leaning forward, a sudden blank expression, all influence the group.

The norms are constructed from both the expectations of members for their group and from the explicit and implicit directions of the leader and more influential members. He feels norms follow logically from discussion of some of the curative factors in the group. These curative factors are outlined and discussed in the first four chapters of his book. They are listed in eleven primary categories viz.: 1) Instillation of hope; ii) Universality; iii) Imparting of information; iv) Altruism; v) The corrective recapitulation of the primary family group; vi) Development of socializing techniques; vii) imitative behaviour; viii) Interpersonal learning; ix) group cohsiveness; x) Catharsis; xi) Existential factors.

The therapist's first task is to create a social system - an interactional network. The members must feel free to comment on the immediate feelings they experience towards the group, other members and the therapist. The therapist must aim for eliciting honesty and spontaneity of expression in the group.

Examples of the type of therapeutic norms that need to be developed are:-

i) A norm that self-disclosure is a necessary component of the therapeutic process. (Yalom warns, however, that the group must not be used as a forced confessional).

ii) Procedural norms - the aim being a group which is unstructured, unrehearsed and freely interacting.

iii) Norms that reinforce the importance of the group. The more important members consider the group the more effective it becomes. A well-functioning group continues to work through issues from one meeting to the next.

iv) Norms that build up members into agents of help. The group functions best if patients appreciate the valuable help that they can provide one another.

Yalom suggests that the therapist assumes two basic roles in the group to help shape these norms in the group:-

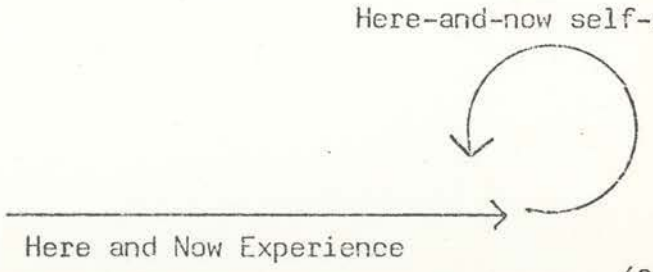
i) The technical expert: The therapist employs a variety of techniques to move the group in the direction he considers desirable. In Chapter 5 of his book Yalom outlines a number of useful examples of the type of technique that may be employed.

ii) The model setting participant. The therapist also shapes the norms by the example he sets in his personal group behaviour. He sets an example of non-judgemental acceptance and appreciation of others' strengths and weaknesses. He can also set an example of interpersonal honesty and spontaneity. This needs to be done circumspectly, however. It must be done in keeping with the developmental stage of the group and the therapist needs to maintain a sense of responsibility and restraint as well as honesty. In addition the therapist can accept and admit his fallibility and use appropriate self-disclosure.

The next major task of the therapist is the activation and illumination of the Here-and-Now. The effective use of the here-and-now focus requires two steps.

i) Activation: The group members must focus their attention on their feelings toward the other group members, the therapist and the group, i.e. immediate events in the meeting take precedence over events both in the current outside life and the distant past of the members.

ii) Process illumination: This must be followed by a process of illumination of what takes place. The group must recognize, examine and understand 'process', i.e. the implications of interpersonal transactions rather than the content of what has been said. To do this the group performs a self reflective loop and examines the behaviour which has just occurred. (See Figure 2).



(25)

Figure 2.

The patient

a) must recognize what it is he is doing with other people ranging from simple acts to very complex patterns unfolding over a long duration of time.

b) must then appreciate the impact of this behaviour upon others and must understand the influence of his behaviour upon others'

opinions of him and consequently upon his own self regard

c) must decide whether he is satisfied with his habitual interpersonal style

d) lastly must be helped to exercise his will to change (every therapist assumes that a patient has within him the capacity to change through wilful choice. Therapists cannot create will but can help remove encumbrances from a bound or stifled will.)

The therapist's function in activating this process is to steer the group into the here-and-now and guide the self reflective loop or process commentary. To achieve his aim he will firstly steer group members away from discussion of outside material and focus their energy upon their relationships with one another. The therapist himself needs to think here-and-now and then this will become second nature to him. He will have to deal with resistance in this process. This resistance can be deeply ingrained and considerable ingenuity may be required to overcome it. In his book Yalom provides well chosen examples of how this can be done.

Like Johnson, Yalom sees that the past does play a part but he states that it should be servant not master. To Yalom it makes sense for the therapist to make excursions into a patient's past when it becomes necessary to understand something which is interfering with that patient's present.

To facilitate process illumination the therapist must himself learn to recognize process. Yalom suggests that he must listen not solely to what the patient is telling but also to what the patient is saying through the process of telling it. The therapist will start by noting simple non-verbal data. Knowledge of

the common group tensions (struggle for dominance, conflicts between mutually supportive feelings and sibling rivalrous ones, between greed and selfless efforts to help others, between the wish to get better and the wish to stay behind in the group) will help the therapist's recognition of process. As will understanding the difference between the primary task of the patient and the patient's secondary gratifications which block him from working on his primary task. The therapist must also attend to his own feelings which may be very diagnostic.

Once he has learnt to recognize process for himself, the therapist must help the members assume a process orientation. He must develop skills to help them achieve self-knowledge through their own efforts. Finally he must facilitate the patient's acceptance of process-illuminating comments.

Unlike Johnson, Yalom does not choose to focus primarily or entirely on what he calls 'Mass group process commentary' (i.e. on the group - we - all of us). He feels this is limiting. He describes himself as an interpersonal process leader so he will frame interpretative remarks to individual group members. He does not, however, question the importance of group level phenomena and he certainly advocates the use of mass group commentary to remove obstacles which arise to obstruct the process of the entire group, e.g. when anxiety laden issues cause group flight.

To conlude this section on Yalom's conceptualization of the role and techniques of the therapist it is necessary to look at his attitude towards the issue of transference. He believes that it does occur and that it is important to recognize its occurrence and manifestations and not to ignore these. On the other hand he

does not believe that all attitudes towards the therapist are transference based. Many are reality based. If the therapist is to make therapeutic use of transference he must help the patient understand, recognize and change his/her distorted attitudes towards the leader. Yalom suggest two major approaches to facilitate transference resolution in a therapy group, viz. consensual validation and increased therapist transparency. The latter is achieved gradually and in a responsible manner so that in time the therapist will relate more personally to group members. In this way early stereotypes that the patients cast onto the therapist become more difficult to maintain. In his belief in therapist self disclosure Yalom differs fairly fundamentally from traditional psychoanalytic therapists, even Foulkes and Anthony.

Yalom points out that there are some patients whose therapy hinges on the resolution of transference distortion; there are others whose improvement will depend on interpersonal learning stemming from work, not with the therapist but with another group member; and there will be many patients who choose alternative therapeutic pathways in the group and derive their therapeutic benefit from other curative factors.

This lends credance to the writer's belief that it is important to provide students with an eclectic approach to group therapy. She feels that the three texts outlined provide a broad base for learning practice skills for the therapeutic milieus. Foulkes and Anthony's book highlights and clarifies for students the unconscious forces and latent conflicts involved in the therapeutic process. Their therapeutic strategy of interpreting

deep seated intra-psychic conflict is an important tool in groups consisting of relatively sophisticated neurotics. Such groups are found in the therapeutic milieus at times. This is an appropriate technique even for individual neurotic patients in more heterogenous groups.

Increasing numbers of patients with personality disorders are admitted to the therapeutic milieus. (Personality disorders do seem to be on the increase and pure neurotic conditions on the wane. This is probably due, in a measure, to the influence Freud has had on Western middle-class child rearing approaches.) For patients with personality disorders the here and now inter-actional approach of both Johnson and Yalom becomes the method of choice.

Johnson's book is particularly helpful in giving students an understanding of the role of anxiety and hostility in group process and how this should be handled. The writer has also found his stress on learning to recognize group themes particularly helpful for guiding students in their direction of group process.

Yalom's fund of common sense, easily understood examples of how a therapist sets about creating and maintaining a therepeutic group structure are a boon to the novice therapist and make his book the basic prescribed text of choice

d) C. Rogers - Client Centered Therapy (1965) - On Encounter Groups (1970)

The writer included the work of Rogers in her course because she feels that his philosophy (although over-optimistic) and his techniques add an important dimension to the therapeutic approach and array of skills that the group therapist can use. His

approach is particularly effective in the beginning stages of therapy when it is vital for the group members to build up trust in the therapist and a feeling of safety in the group.

Rogers developed his practice philosophy in the 1940s. This era was the heyday of American optimism and self confidence. It is not surprising therefore, that he over-accentuated the goodness and worthiness of man. Despite this, there is much to commend the philosophical notion of unconditional acceptance of the client as a person and the belief in his ability to help himself.

In viewing the role of the therapist the previous three authors stressed the therapist's role as the technically skilled authority figure. One implication of this could be a therapist who grows to see himself as a superior god-like being and to visualize the group members as lesser mortals. Shulman (1968) quotes Piaget as pointing out that the adult's domination of the child lays the groundwork for the emergence of the prevalent dominance - submissive value towards human relationships in our culture as opposed to one based on equality and reciprocity. Thus, in Western culture we tend to see alternatives in human relationships as limited to being on top or bottom. Shulman states that the opportunity for learning different skills necessary for dealing with others on the basis of equality are limited in our society.

As the development of interactional skills in group therapy is designed inter alia to increase feelings of self worth and self esteem it would seem that adding a flavour of this democratic stance to the role of the therapist would be worthwhile.

The role of the Rogerian leader or facilitator is determined largely by his philosophical outlook and attitudes towards people culminating in the confidence he has in their competence to direct themselves. The therapist must be non-directive. This does not mean he is passive. It implies, rather, that he withholds judgement about the client's behaviour, his past history and his future goals. The only value to be transmitted to the client is that of self determination. The therapist must show unconditional acceptance of the client as a person and this must be congruent i.e. the therapist must not subtly guide the person while pretending to let him guide himself. He must be genuine in his approach.

The technique used by the therapist is to clarify and objectify the client's feelings in a calm and empathic manner. This is not interpretation. There is a simple acceptance of what the client says and this is reflected back to him in the form of a restatement of the content. This is a very effective technique when the therapist wants to convey acceptance and support to group members.

However, it is not enough. As Yalom points out, in the analysis of essential leadership functions by Lieberman et al, emotional stimulation and cognitive structuring were seen to be as essential. The Rogerian factors of empathy, genuineness and unconditional regard fill only the one category of Caring.

e) F. Perls - The Gestalt Therapy Verbatim (1971) - The Gestalt Approach and Eye Witness to Therapy (1976)

The Rogerian concept of self determination serves as an antidote to the effect of the Freudian concept of psychic determinism which

provides some patients with a wonderful excuse for maintaining the secondary gratification of the sick role - 'I am the victim of the ills perpetrated on me by my parents in my childhood so there is nothing I can do about it'. Thus, insight into past conflicts may serve as a justification to remain neurotic, and as an excuse for refusal to face up to the responsibilities of current life situations.

The concept of self determination propounds a belief in the person's ability to help himself but makes no allowance for the force of the resistance to change which becomes apparent at some stage in the life of the therapy group.

Yalom (1975) is very critical of Perls' use of the group in Perls' Gestalt therapy but acknowledges two of his areas of strength viz. i) Perls' acute awareness of the necessity for each individual to assume responsibility for himself and his therapy and ii) Perls' therapeutic attempts to penetrate the denial systems of people and bring them to a new perspective on their position in the world. It is these strengths that make him the writer's final choice of therapist/author in her group therapy course. Although agreeing with Yalom that Perls makes inefficient use of the therapeutic potential of the group, using it as a congregation of individuals or 'omnipresent Greek chorus'[26] rather than a fully-fledged therapeutic tool the writer feels students should become acquainted with some of his concepts and techniques.

Perls defines a neurotic as

> a person who chronically engages in self interruption, who has an inadequate sense of identity ... who has an inadequate means of self support, whose psychological homeostasis is out of order and whose

> behaviour arises from misguided efforts in the direction of achieving balance.
>
> .....
> The neurotic finds it difficult to participate fully in the present - his past unfinished business gets in the way. His problems exist in the here and now and yet too often only part of him is here to cope with them.

Thus Perls sees the aim of therapy as helping the person to live in the present and therapeutic sessions must be his/her first practice at this hitherto unaccomplished task. The main goal is to make the neurotic self supportive and no longer at the mercy of interrupting forces he cannot control.

Gestalt therapy is an experiential rather than verbal or interpretive therapy. Patients are asked to re-experience their past traumas and problems, i.e. their unfinished business, in the here-and-now, rather than talk about them. Perls puts his emphasis on a patient's areas of awareness rather than his areas of unawareness with the hope that the patient will become progressively more aware of himself at all levels, phantasy, physical and verbal, and he may then see how he is producing his difficulties, what his present difficulties are and how he can help himself solve them in the present.

Perls employs awareness techniques. The basic sentence which the therapist instructs the patient to use in order to induce the patient's self awareness is 'Now I am aware of ....'

> The now keeps us in the present and brings home the fact that no experience is ever possible except in the present ....
>
> The 'I' is used as an antidote to 'it' and develops the patient's sense of responsibility for his feelings, thoughts and symptoms
>
> The 'am' is his existential symbol. It brings home whatever he experiences as part of his being .....

> The 'aware' provides the patient with the sense of his own capacities and abilities, his sensoric, motor and intellectual equipment ..... gives both therapist and patient the best picture of the patient's present resources. (29)

According to Perls the therapist questions the patient in this process of developing awareness, asking 'what do you feel, what do you want, what do you avoid or what do you expect?'in order to help the patient see his behaviour more clearly and determine for himself what the behaviour represents. Neurosis is conceptualized as being like an onion and Perls maintains it is only possible to peel off one layer at a time and that at each step of the way the patient's self support is increased and the next step becomes easier to take. To reintegrate the neurotic step by step the therapist must challenge any statement or behaviour which is not representative of the self and which is evidence of the patient's lack of responsibility.

In a modified form this type of approach can be used to very good effect in the therapeutic milieu therapy groups and is so used. Thus, when it becomes evident that a patient is ready to work on him/herself, he/she can put into what is called the hot seat in the group, i.e. both therapists and members can focus on an individual patient for part of a session and confront that patient in order to help him/her look at his/her behaviour patterns and then take responsibility for changing them.

In addition to this, Perls' experiential techniques of re-experiencing past unfinished business in the present are valuable particularly when ventilation of repressed infantile anger is required to achieve catharsis in patients.

Thus, these two humanist-existential practitioners offer approaches and strategies that are useful adjuncts in a group therapist's repertoire of skills. Rogers' approach is most helpful in the beginning stages of therapy and Perls' in the working phase.

f) Teaching Methods

In planning and executing a theory course on group therapy for Clinical Social Work students, cognizance has to be taken of the learning pressures of the Clinical Social Work Master's programme as a whole. This pressure is a factor in all the theoretical programmes offered to the various psychiatric disciplines.

Despite careful planning of the course in 1982 the writer found 6 one-and-a-half hour sessions insufficient for adequate coverage of the theoretical material outlined in this section.

The writer confined her list of prescribed reading to a minimum. Students tend to become discouraged by a lengthy bibliography and, as a result, some do even less reading than they would otherwise do. Students were required to read H. Northen's - Social Work in Groups, and I Yalom's The Theory and Practice of Group Psychotherapy before the course started.

The writer gave three didactic lectures on groupwork and group therapy models, group dynamics and processes and diagnostic assessment. For these lectures the students were required to read the following (in addition to the relevant sections in Yalom and Northen's books):

Douglas, T.: A Decade of Small Group Therapy

Glasser, Sarri and Vintner: Individual Change through Small Groups Chaps. 5, 10, 11, 15, 16.

Johnson, J.: Group Therapy. Chaps. 3, 4 and 5.

Northen, H.: 'Psychosocial Practice in Small Groups' in Theories of Social Work with Groups ed by Roberts & Northen.

Papell, C.P. and Rothman, B.: Social Groupwork Models: Possession and Heritage

Thereafter the students had to prepare seminar papers on the Role and Techniques of the various theorist/practitioners outlined in Section E. These papers had to be typed and copies handed to each student for reading before the seminar session. The students were expected to present their papers by role playing a group therapist using the approach and techniques outlined in their papers. The rest of the class acted as group members. This method of presentation was not entirely successful as the students were not yet skilled enough to highlight actual techniques. However, the role playing proved to be extremely valuable for helping the class look at group dynamics and development, and it helped them start testing our their skills. Noteworthy was the final meeting in which a termination meeting was role played and the class was actually able to experience a certain amount of termination feeling.

The writer concludes, therefore, that this teaching aid be retained in a modified form in the course. She is also of the opinion that it would be beneficial to give a further series of seminars once all students are actually in practice. In these seminars greater integration of theory and practice could be achieved by testing out various techniques through role playing actual practice situations.

The theoretical foundation for group therapy practice is therefore provided through a structural course of prescribed

reading, didactic lectures, seminar discussions and role play.

3. Attending an Experiential Group

The writer has already stated her case for advocating the need for experiential group experience as an essential training requirement. Her arguments are backed by the informed opinions of Foulkes and Anthony, Johnson and Yalom. As Yalom (1975) points out a personal group experience has been widely accepted as an integral part of a training group. The accreditation committee of the American Group Psychotherapy Association has recommended a minimum requirement of 60 hours.

This need has been recognized by the Clinical Psychology, Clinical Social Work and Psychiatric Nursing disciplines attached to the University of Cape Town and Groote Schuur Hospital, and all trainees in these disciplines attend an experiential group.

There are a number of issues regarding this aspect of the training programme that need to be considered.

The first is the question of length or number of hours. The Clinical Psychology Interns and Psychiatric Nurses attend a group for the whole academic year. The Clinical Social Work students at present have a short-term group. Yalom's preference is for the group to continue throughout the entire training programme. He considers experiential groups of Clinical trainees difficult to lead because the pace is so slow, intellectualism so common and self disclosure and risk taking minimal. This is because these students tend to feel that their personal and professional competence is at stake. This writer's experience of supervising students who have been in a very short-term

group have led her to agree with Yalom with regard to the desirability of a longer group experience. She found that students who had been in a short-term group had not even resolved issues of basic trust in their experiential group. These students felt that they had remained very defensive in the group and had certainly not felt safe enough to express hostility towards their leaders. As a result they had great difficulty in dealing with the anger of patients in their group therapy practice. The writer found that she had to use some structured evocative techniques with the students during supervision sessions in an attempt to reduce this block. Therefore, it is important for an experiential group to move through all the developmental stages outlined by Northen (1969) in order to be a really effective learning experience.

Leader selection is another important issue. The group experience is likely to be an extraordinarily influential event in the student's training career. As Yalom points out the leader will often serve as an important role model for the trainees. Therefore, selection of a leader or leaders is of the utmost importance and both personality factors and skill need to be considered. Yalom feels that both these factors should influence choice rather than professional considerations. The writer agrees with Yalom that, if at all possible, the leader should not be a member of the staff of the teaching programme. There is no doubt that students feel restricted by the presence of someone who will play an evaluative role in their career. It is also extremely difficult for one person to play two opposing roles, i.e. the role of an accepting, non-judgemental group leader and at the same

time the role of tutor or supervisor who must evaluate the student in terms of the training course requirements. It is also important that the group should not be used to talk about practice issues, which belong in supervision, as a defence against looking at more personal issues. Yalom's suggestion that a trainee's first group experience should not be one of a highly specialized format is another valid consideration when selecting a leader.

The final issue to be considered is whether attendance of the group should be voluntary or compulsory. Motivation is always an important factor in the effectiveness of an experiential group. Resistance slows up the process. Therefore, a voluntary group of motivated members is likely to be more effective than a group with some ambivalent or resistant participants. On the other side of the coin, if a student refuses to join a voluntary group because of a distrust or dread of group situations the question of his/her suitability to pursue a career as a clinician remains unsolved.

Perhaps the answer to this dilemma is to build in the experiential group as an integral part of the course so that students are aware of and accept it as part of their learning contract when applying for admission for the course. Any student who is resistant to taking part in a group that is therapeutic even if not a therapy group per se would then be counselled out during selection.

4. Practice of Group Therapy

Today it is taken for granted that actual practice is an essential component in the acquisition of the necessary skills of a group therapist.

The therapeutic milieus are the major practice placements for all four psychiatric disciplines. Mention has already been made of some of the complexities and difficulties associated with the group therapy learning experience in these placements viz. the open-ended nature of the groups, constant change of therapists, difficulties of working with co-therapists and the rapid development of group process due to the frequency of meetings. Nevertheless the intensity of the experience and the fact that the groups are linked to the totality of the therapeutic milieu experience makes these groups the most valuable learning experience in the practice of group therapy offered to students. The students learn to perform at far greater depth and at a far more sophisticated level than they do in groups held only once a week.

The writer feels that there are solutions for some of the difficulties and that steps can be taken to compensate for the complexities and to ensure that the students get the maximum benefit out of the group therapy experience offered in the therapeutic milieus. In this respect the needs for a theoretical background, experiential group experience and supervision are discussed in Sections 2, 3 and 5.

Yalom (1975) talks about the value of observing experienced clinicians at work as part of a training programme. This is not a facility that the therapeutic milieus can really offer as the group therapy is undertaken mainly by trainee therapists. Medical students and certain other students such as occupational therapy students and student nurses do observe group sessions from behind the one-way mirror or by sitting in as observers at Psychiatric

Day Hospital. However, the writer considers this to be a meaningless experience for students unless they can take part in a feedback session in which group dynamics, themes and interventive strategies are discussed and evaluated after the group meeting.

In view of the complexities of the group dynamics and the fact that group development takes place so rapidly in these groups the writer considers it important that students should have previous experience of conducting a closed group that is run once a week before undertaking the facilitation of the therapeutic milieu groups. In a closed group students are exposed to a clearer picture of developmental processes and the stages occur at a slower pace thus enabling the student to benefit from his/her own and the supervisor's critical evaluation prior to each group session. In this way the student develops some diagnostic skills before attempting on-going diagnostic assessment of the rapid movement of the therapy groups in the therapeutic milieus.

When deciding on practice placements for clinical social work students this writer would stipulate prior experience of running a closed group as a prerequisite for group therapy practice in the therapeutic milieus. For students who have not had previous experience of running closed groups the clinical practice component would be confined to running a weekly closed group. However, this may not be a practical prerequisite for the other psychiatric disciplines notably for psychiatric registrars and nurses.

Johnson (1963) advocates the use of recorders in training programmes. The recorder sits in as a non-participant note-taker. As the recorder is a regular feature of the group, initial group

suspicion and discomfort at the presence of a silent observer can be worked through by the therapist with the group members and they soon get to the stage of taking the recorder's presence for granted so that it does not affect group process adversely. It is far easier for a group to handle their feelings about a regular observer than it is for them to cope with casual students who go into the group as observers for short periods, often causing the group to have to rework through issues of mistrust during critical working phases. Johnson feels that recorders play an extremely valuable role. It is not possible for a trainee therapist to remember everything that happens in a group session. To have a written transcript to refer to is very helpful. Apart from this the recorder can give the therapist feedback about the way he comes across non-verbally in the group. A recorder can be just as much a support and ally as a co-therapist especially as the difference in role eliminates a large element of competition. Recorders should attend regular supervision sessions with the trainee therapists. As the recorder's only job is to observe he/she can learn to pick up group dynamics and processes far more easily than the trainee therapist who is constantly searching for the correct approach and response to all the group stimuli as well as learning to observe them.

The continuity of regular observation makes it of far more benefit than the haphazard observations of more casual observers who may not clearly understand the group dynamics of an observed session because they missed watching the previous sessions.

The writer considers that potential therapists can learn a great deal from being a recorder. She found that acting as a

recorder during her own practice experience as a student added an important dimension to her learning experience. The commitment attached to the role of recorder, particularly in terms of the production of written material which can be analysed in greater depth and detail, makes this a far more intensive learning experience than that of a mere observer. The writer, therefore, advocates that students who have had no previous experience of running groups act as recorders in the therapy groups in the therapeutic milieus for a short period before moving into the group in the role of therapist.

5. Supervision

Intensive and regular supervision is recognised as being as important as actual practice experience in trainingprogrammes for both individual and group therapists. The psychiatric registrars clinical psychology interns and clinical social work students working in the therapeutic milieus get this close intensive supervision of their individual therapeutic work at least once a week. Supervision is provided by experienced clinicians of the same profession who are attached either to the therapeutic milieu or the relevant University departments. Clinical social work students get regular supervision from both the therapeutic milieu social workers and University supervisors. However, apart from the clinical social work students who get regular group therapy supervision, supervision of group therapy practice is not given to the same extent. Yet group therapy is a far more complex skill to develop than individual therapy.

Yalom cites a study that he and his colleagues undertook of twelve non-professionals who led groups in a psychiatric hospital. He states:-

> Half of the leaders received ongoing supervision as well as an intensive training course in group leadership; the others received neither. Naïve observers rated the therapists at the beginning of their groups and six months later. The results indicated that not only did the trained therapists improve but the untrained therapists, at the end of six months, were less skilled than at the beginning. Sheer experience, apparently is not enough; without ongoing supervision and evaluation, original errors may be reinforced by simple repetition. (30)

Yalom recommends one supervisory hour per one hour group therapy session as being the optimal ratio; that supervision should take place as soon as possible after the group session,preferably the following day; that ideally the supervisor actually observe the last 30 minutes of each meeting and hold the supervisory session immediately thereafter.

Such a supervisory programme is totally impractical for a group therapy experience that takes place four times a week. This type of practice programme does impose a number of supervisory problems. The writer will outline how group therapy supervision is dealt with in the Clinical Social Work Master's programme. As with the theoretical foundation outline in Section 2, she will propose that this outline serve as a basis for the consideration and evaluation of all psychiatric disciplines with a view to developing a system of common supervision of co-therapists in the therapeutic milieus.

Most writers on supervision suggest that the supervisor's role involves three distinct functions, viz. an administrative function, a helping or enabling function and a teaching function.

In the therapeutic milieu placements supervision is shared by the Psychiatric Social Worker employed in the therapeutic milieu and the University supervisor. The former is responsible for most of the administrative functioning, e.g. arranging when the student will actually go into the group as a co-therapist. She also carries part of the helping or enabling function as she serves as a constant supportive presence in the setting and acts as a mediator between the student and the rest of the staff team when necessary. The bulk of the teaching function falls onto the shoulders of the University supervisor. In this outline the writer will concentrate on the supervision given by the University supervisor.

A. Supervision by the University Supervisor

In the Clinical social work programme a group supervision session is held with the University supervisor for one-and-half hours once a week for the period in which students are in practice. In addition students are required to attend three individual supervision sessions. In the first of these sessions the supervisor and student together formulate an educational diagnosis and establish a contract with regard to the learning needs and growth goals of the student. This contract forms the basis of supervisory teaching focus. The main areas of supervisory focus are on the development of relationship skills, the development of diagnostic skills and the development of interventive skills, and finally the development of insight into own personal functioning and patterns of reaction. The second individual session is a mid-evaluation in which progress is evaluated and further growth goals formulated. In the final

session the student gives an oral presentation of his/her group therapy experience before a moderator, a final evaluation takes place and a mark for performance is allocated. (See Appendix B for the guide to evaluation currently in use in the Clinical Social Work programme).

As supervision takes place only once a week any student who wants to discuss a problem urgently may arrange for additional time on an individual basis. If the supervisor is concerned about a student's performance she may also ask the student to come and see her individually. Where there is a one-way mirror the supervisor does watch group sessions periodically and provides instant feedback. If possible she watches the student at least twice.

B. The Helping or Enabling Function

Group supervision is the supervisory method of choice as there are similarities between processes occurring in therapeutic groups and those occurring in supervisory sessions. As Walton et al (1971) point out "being supervised together in a group of more or less constant composition and by the same supervisor the trainees themselves experience the consequences of belonging to a group and working together"[37] They have the advantage of peer group learning, hearing about the group experiences of fellow students in addition to discussing their own, and of making suggestions to each other with regard to alternative ways of handling certain situations. It is also very comforting to a student to learn that other students are equally anxious and battle with the same problems as he/she does.

As Yalom (1975) points out the supervisor can obtain much information about the trainee's behaviour in his therapy group by attending to his behaviour in the supervisory group. The supervisor needs to draw attention to the student's own attitudes and emotional reactions. In this she cannot but play a limited therapeutic role. It is important, however, that the supervisor does not become therapist. Helping students obtain insight into themselves must be work focused, i.e. only patterns of behaviour, emotional blocks and resistances that affect the student's role as group therapist need be touched upon. It will be assumed that the student has sufficient ego strength to work through these on his/her own. If this should not be the case it is the student's responsibility to seek outside therapeutic help.

Ideally, as Walton et al (1971) suggest, the supervisor in group supervision should react more in the style of a conductor or facilitator rather than function as a teacher or instructor i.e. should leave most of the discussion to the students themselves. However, as they also note, this type of active participation develops slowly. This writer finds that the period of University supervision is too short-lived for her to move from the central role in the group. She finds that she has to use supervision for a great deal of active teaching. If her suggestion of further seminars added to the theory component were to be implemented more attention could be focussed on this aspect of reacting more as a conductor in group supervision.

C. The Teaching Function

For supervisory purposes students are expected to submit written process records of each meeting. This record includes a face sheet with i) number of the meeting; ii) Date of meeting;

time begun and ended; iii) names of student/therapist and co-therapist; name of placement.

The report consists of i) names of all members, indicating absentees and reason for absence if known; ii) a seating diagram; iii) a detailed process recording of the meeting; iv) Evaluation of the group and its stage of development and themes; v) Observations of individual members; vi) Evaluation of own functioning in the group; vii) Any aspects or problems which are to be brought up for discussion in supervision; viii) Goals for the group and individual members.

It is impossible for the students in the therapeutic milieus to produce full process records of four meetings a week. These records are lengthy documents and take time to write. The writer thus, requests students to write a full process record of one meeting a week and short summary reports of the other three meetings. In their full report group evaluation they are expected to note and evaluate the themes and development of all four meetings during the week. If this is not done students and supervisor tend to get a vertical perspective of group process, in other words, examination of only one meeting in detail causes loss of a horizontal perspective of group development.

These records are handed to the supervisor prior to the weekly supervision meeting. She then analyses the reports making pencilled comments, suggestions and criticisms in the margins. She will also point out certain issues which provide good material for group supervision discussion and suggest that the students bring these up for discussion in the supervisory session.

From the point of mid-evaluation, students are increasingly expected to undertake this type of detailed evaluation for themselves, thereby increasing their autonomous functioning and development of a pattern of on-going critical self evaluation, which should not cease when they qualify and abandon their student role.

The writer considers these written records are essential for supervisory teaching purposes. There is criticism of the use of such records in terms of the allegation that they are found to be highly selective and distorted. Whenever possible students are asked to tape record meetings and to use these recordings for writing their reports. The use of a recorder who produces a report of the same meeting is another form of control. Actual observations by the supervisor, from behind the one-way mirror, of group sessions in progress provide a further check that the student does in fact perform in the manner outlined in reports. This writer has compared the reports of trainees and recorders and has not found the degree of distortion so great as to make these records useless for teaching purposes. Group process is too complex for successful, deliberate, distortion to take place. It is possible to pick up group themes and processes even in a selectively written report. In her experience as supervisor the writer has found that the student who produces detailed reports with well thought out evaluations makes the most progress in learning to become a skilled therapist. The majority of students claim that the supervisor's written comments and analysis have provided one of the most beneficial of their learning aids.

Students are also expected to prepare a preliminary written profile on each group member. This should be based on both the history and diagnostic formulation presented by the individual therapist and on the student's own observations of the member in the group. The tentative goals for the member should be included in the profile as well as in the process records. After the student has completed his/her spell of group therapy the profile of each member should be brought up to date and should reflect the student's observations of the member's participation in the group and any changes or growth that has occurred in the member. A copy of this profile should be placed in the patient's hospital file.

At the end of the placement students are expected to write a group summary report of their clinical group therapy practice. These reports are to reflect the students' integration of theory and practice. It is felt that these final reports enable students to draw all the threads of a complex learning experience together and provides the students with an invaluable cognitive overview of their total experience.

PART III

CONCLUSIONS

CONCLUSIONS

Mastering the art of becoming a skilled practitioner of group therapy is a complex procedure. Learning to practice group therapy in the therapeutic milieu placements outlined in Part I poses challenges to both trainee therapists and those responsible for their training. These therapeutic milieus provide an exciting learning setting in which students, from all the psychiatric disciplines, can gain a depth of understanding and achieve a sophisticated level of functioning in group therapy provided they are able to make maximum use of the opportunities afforded in the placements.

In order to make it possible for students to do this, the writer has advocated the formulation of a training programme which contains four essential components:

(1) A structured theory course in which a theoretical foundation is gained through prescribed reading, didactic lectures, seminar discussions and role-play.

(2) Attending an experiential group conducted by a skilled leader for a sufficient duration to allow the students to experience all the phases of group development outlined in the Life Cycle developmental model.

(3) Actual practice of group therapy which will take place in the therapeutic milieus only after students have had previous experience of running a closed group or have acted as a recorder in the therapeutic milieu therapy groups.

(4) Provision of regular, intensive supervision of this practice. This supervision should preferably be group supervision and where and whenever possible should include actual observation

of the student conducting a session from behind a one-way mirror.

As the group therapy practice in the therapeutic milieus is undertaken by co-therapists drawn from all four psychiatric disciplines it is felt, that for these students, a large part of the training programme should be common to all four disciplines. This applies particularly to the theoretical foundation and supervision. With this in mind the writer has outlined the theoretical foundation and supervisory practice provided in the Clinical Social Work Master's programme at this point in time, in the hope that this will provide a basis for interdisciplinary discussion and evaluation with a view to formulating some common training requirements for the practice of group therapy in the therapeutic milieus.

She proposes the following:

A. That discussion be instigated between those responsible for the training programmes of the four psychiatric disciplines to consider a) the importance of group therapy; b) the need for improved training in group therapy; c) the need for common training in group therapy; d) the four training components outlined by the writer as essential in any training programme.

B. i) That the writer's outline in Section 2, Part II, be used as a basis for critical evaluation and discussion with a view to formulating a common syllabus for the theoretical foundation for group therapy practice.

ii) That consideration be given to a common learning experience for trainee group therapists from all four disciplines in which lecturers or tutors from all four disciplines contribute to the programme by giving didactic lectures, or conducting seminars or workshops.

iii) That, owing to the pressue of the University training programmes, some of the training be given on an in-service basis in the therapeutic milieus in the form of weekly supervision/seminar sessions.

C. i) That, in view of the need for skilled experiential group leaders and group therapy supervisors, serious consideration be given to the establishment of an Association of Group Therapists or Group Psychotherapists similar to the present S.A. Institute of Psychotherapists.

ii) That the aims of the Association of Group Therapists should embody inter alia:-

a) Prescription of the necessary qualifications and experience for the practitioner of group therapy to be deemed a group therapist or group psychotherapist

b) Instigation of advanced training programmes for group therapists

c) Formulation of a common value system for group therapists from different disciplines

iii) That membership of such an Association be multi-disciplinary

iv) That membership be confined to those who qualify in terms of the standards prescribed by the Association.

D. That, once such an Association is established, only members of the Association be considered as leaders of the experiential groups for trainee group therapists.

E. i) That the University Departments involved in training students for clinical practice together with the Authorities involved in staffing the therapeutic milieus in the Provincial Hospital service consider appointing a multidisciplinary group of supervisors whose job would be to provide the necessary regular intensive supervision of all the trainee group therapists in all the therapeutic milieus.

ii) That this supervision be done in groups consisting of the co-therapists and recorders of both orientation and working groups. Students from more than one therapeutic milieu could be supervised together.

iii) That the writer's outline in Section 5, Part II provide a basis for evaluation by the group of supervisors with a view to formulating common supervisory standards for practice.

iv) That, ideally, supervisors too should be drawn from the ranks of the proposed Association of Group Therapists.

In conclusion the writer would like to affirm her belief that group therapy is one of the most rewarding and important of the therapeutic methods and that increasing attention should be given to training in this method especially for practitioners working in institutional settings.

APPENDIX I

J.L. Stricklin's Developmental Dynamic Diagnostic Statement is the final working document formulated in The Psycho Social Index Second Ed. Revised - Cape Town: University of Cape Town Printing Dept. 1974.

This document contains the following sections:

(i) Organic
(ii) Intellectual/Cognitive
(iii) Basic Personality
(iv) Current Ego Functioning
(v) Environmental Influences

DIAGNOSIS

RECOMMENDATIONS

The writer had a number of discussions with Dr. Stricklin with regard to the relevant factors that should be considered under each section of the statement. The factors listed below are the writer's interpretation of the type of relevant information that would be considered under each section. Only those factors that are pertinent for the recommendations for therapeutic intervention should be listed.

(i) Organic

1) Any significant disease
2) Any signifcant periods of hospitalization
3) General state of health
4) General age level comparison re weight, height, etc.
5) Level of energy
6) Psychosomatic manifestations
7) Any degree of organic impairment

(ii) Intellectual/Cognitive

1) Approximate IQ
2) Interview behaviour, language, understanding
3) Ability to process the environment and to problem solve realistically
4) Ability to do for self
5) Memory
6) Is potential realized.

(The information in this section should provide a rough assessment of how able the client is to enter into any therapeutic relationship)

(iii) Basic Personality

(It is important to distinguish this area from Current Ego Functioning)

It refers to the habitual modes of responding and behaving. Basic Personality results from early developmental history so it may be viewed in terms of psychodynamic concepts

1) Superego - "Good", conscientious, overly demanding irrespondible.
2) Ego - strengths and weaknesses in coping with the environment
3) Id - or motivational forces - are these controlled or acted upon spontaneously?

Can look at the following areas

dependency, ability to trust, expression of aggression, anxiety, self concept, sexual identification.

NB. Will look at both adaptive and maladaptive modes of responding.

(iv) Current Ego Functioning

How the individual is reacting to the stress or problem at this time i.e. current manifestations
Can look at current relationships; thought processes; use of consciousness
Ability to perceive reality; awareness of self and of actions, level of anxiety; mood - is it appropriate; motivation; impulse control, what defence mechanisms are being used.
NB. Will look at both strengths and weaknesses.

(v) Environmental

Both past and present environmental factors will be considered.

1) Significant relationships - parental, sibling, marital, etc.
2) Family interrelationships e.g. does extended family play a part.

3) Particular stress/trauma
4) Developmental stage
5) Political/Economic/Religious/Cultural Factors.
6) Long-term/precipitating

NB Both positive and negative factors should be considered.

Recommendations (Therapeutic Intervention)

1) Medical examination necessary
2) Psychological testing
3) Individual therapy
4) Group therapy
5) Relationship therapy (parent counselling, marriage guidance, family therapy)
6) Use of specialized services e.g. speech therapy
7) Environmental manipulation.

APPENDIX 2

School of Social Work
University of Cape Town

M.Soc.Sc.(Clinical Social Work)

Guide for the Evaluation of Student Progress in Group Therapy/Advanced Groupwork

I. Level of development at the beginning of the course:

(a) Previous theoretical training

(b) Previous experience

(c) Felt needs for learning.

Evaluation

II. Functioning of Student:

(a) Ability to observe and respond appropriately to:

(i) Individual feeling and behaviour

(ii) Individual's effect on member/group

(iii) Group behaviour

(iv) Group's effect on individuals

(v) Worker's effect on individuals and group.

(b) Ability to set goals and to work purposefully towards these:

(i) For individual members

(ii) For the group as a whole.

(c) Ability to use the interaction process:

(i) Relating member to member, member to group and group to member in order to develop a free interactive network.

(d) Ability to use self for therapeutic purposes:

(i) Relating to members/group/agency

(ii) Accepting members/group/agency

(iii) Limiting behaviour harmful to self or others/ destructive to material or relationships

(iv) Guiding discussions, activities, group movement

(v) Appropriately alleviating tension, conflict, fear, anxiety, guilt

(vi) Enabling and supporting individuals/group to

- accept selves and others
- express themselves
- involve themselves in discussion, decision-making, assuming and carrying responsibility.

(vii) Ability to make purposeful use of process commentary.

(e) Ability to assess and evaluate:

(i) Unconscious motivation of individual/group behaviour

(ii) Group process

(iii) Stage of group development

(iv) Your own feelings in the group and how these affect your interventions.

(f) Ability to plan purposefully based on your assessments in (e).

(g) Appropriate handling of termination of group.

(h) Ability to use supervision (including assessment of own learning needs).

(i) Relationship with Agency Staff:

(i) Appropriate feedback to Agency staff

(ii) Ability to work within Agency policy

(iii) Ability to select pertinent information for written profiles on members required by the Agency.

Marks for group work practice will be assigned according to the following criteria:

1st class: By the end of the placement, has developed all of the skills well and uses them appropriately.

Upper 2nd class: By the end of the placement, has developed all of the skills well and uses them appropriately but sometimes still has difficulty with one or two of them.

Lower 2nd class: By the end of the placement, has developed most of the skills and uses these appropriately.

3rd class: By the end of the placement, has developed most of the skills and uses them appropriately but sometimes still has difficulty with one or two of these.

9.2.82

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