Failures in Group Psychotherapy: The Therapist Variable

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ABSTRACT

Failures in group psychotherapy are well-known to practitioners in the field. The author contends that the unresolved, irrational fears of the therapist, in particular the fear of abandonment and the fear of engulfment, are major contributors to failures in group psychotherapy. Clinical vignettes are used to illustrate the impact these fears of the therapist have on patients at the initial, middle, and end phases of therapy. The author suggests ways to recognize the potential for failure and recommends several methods by which therapists can help themselves diminish failure in group psychotherapy.

The therapist's personality and character, in particular his or her irrational fears, have a profound impact on failures in group psychotherapy. It is surprising to discover, however, that even though the group psychotherapy literature recognizes the importance and centrality of the therapist in the group, the contributions of the therapist's personality, character, and unresolved psychopathology to failure are rarely discussed. Most often, when this subject is addressed the focus is on variables relating to patients and not to the therapist. The therapist's contribution to failures can be gleaned only indirectly from the literature. Several examples from the countertransference and patients' variables literature will demonstrate the paucity of information on this subject.

In Yalom's (1975) list of nine reasons for patients dropping out of psychotherapy (p. 225) the therapist's role is not mentioned. The

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focus is on the patient's internal motives and on external circumstances that lead to premature termination. Rutan and Stone's (1984) group dynamics, existential perspective on termination as well as Mullan and Rosenbaum's (1978) six factors "false termination" list do not consider the therapist's role as a variable contributing to failures in psychotherapy.

The leadership style studies of Lieberman, Yalom, and Miles (1972), and Lieberman (1972 & 1990), link negative outcome to the type, behavior, and style of the leader. Friedman (1989) considered the "therapist burnout" to be the therapist's contribution to successful termination. Only inasmuch as these variables are expressions of the therapist's personality could one then deduce the connection between the therapist's personality and failures.

Because the countertransference literature examines the unconscious reactions of therapists to patients it would seem to be a natural resource of clinical expositions of failures in psychotherapy. However, in that literature the focus is not on the personality, character, and psychopathology of the therapist. For example, Spotnitz (1976), Rosenthal (1987), and Ormont (1988, 1991) discuss the importance of countertransference and imply that the therapist's recognition and awareness of the countertransference in and of itself yields positive results in treatment. They focus on the successful rather than the unsuccessful resolution of the countertransference process.

Wolman (1976) attributed failure to the exploitation of transference by the therapist. Rosenzweig and Folman (1974) examined patient and therapist variables in their study and concluded that "the therapist's feelings towards the patient and his feelings about how long he expects the patient to remain may carry with them a self-fulfilling prophecy" (p. 78). Weiner (1983) in exploring the impasse in group psychotherapy concluded that "the most subtle and most potentially destructive factor is the therapist's narcissistic vulnerability" (p. 320), his need to be treated in certain ways by patients in order to treat them. That need is especially intense at times of crisis in the therapist's life. Certain patients deny therapists the gratification that the therapists need to do effective psychotherapy. West and Livesley (1986) attribute the failure in the relationship between the group members and the therapist to the therapist's inability to maintain "anonymity, total confidentiality, and neutrality" (p. 16).

FAILURE IN GROUP PSYCHOTHERAPY: DEFINITION AND VARIABLES

The focus of this article is on the irrational fears of the therapist that contribute to failure in group psychotherapy, and on the impact of these fears at various phases of treatment. The therapist is considered here to be the epicenter around which the therapeutic process evolves. Group psychotherapy as discussed here is based on the principles of the Crisis Mobilization Therapy elucidated by Bar-Levav (1988). The therapeutic objectives are to cure depression utilizing intensive, long-term, combined individual and group psychotherapy. The eight principles underpinning this method: the surgical model, establishing a strong real relationship with the patient, working with feelings, thinking, and the body, combining individual and group therapy, and developing emotional dependency, which makes up a clinically integrated system that can be used only with the free and informed consent of the conscious patient. Although the following clinical cases were selected from a private practice using this system, the clinical and theoretical principles presented may nonetheless apply to other settings and situations.

In this discussion the general definition of failure in group psychotherapy is any premature termination of the psychotherapeutic process before the patient is cured, not caused by external, technical, or situational factors (Nobler, 1986) such as relocation, physical illness, lack of funds, institutional constraints, or acts of God.

This author adheres to several fundamental principles. First, everything that happens in the therapeutic relationship is the result of the interaction between the conscious and unconscious processes of the patient, and the conscious and unconscious processes of the therapist. Second, the therapist is the instrument of change. Both require him or her to scrutinize repeatedly his or her conscious and unconscious motivation, feelings, thinking, and behavior in the relationship with a patient. It follows therefore that any premature termination must be considered as resulting at least in part from some shortcoming in the therapist.

This is an unpopular perspective for many therapists who feel it as too heavy a burden to bear, perhaps because it deprives them of using rationalizations to spare their feelings. It disallows faulting the

patient or the patient's pathology for the failure of treatment. To the degree that the therapists' self-image is dependent upon their work they would want to protect this image and not see themselves as having failed.

Responsible therapists who feel guilty and tend to blame themselves may find it extremely difficult to be honest with themselves by really exploring their failures. To accomplish this one must accept the principle that the therapist is the instrument of change, and therefore it is his or her personality and character, more than mere technical skills, which determine the success or failure of therapy. Consequently, even though some therapists will experience what follows as an extreme position, it would be very useful for each therapist to consider that EVERYTHING that happens in the therapeutic relationship is at least in part influenced by the therapist's characteristics.

Of critical importance are the irrational, unresolved fears of the therapist and their impact on the therapeutic process. Just as it is true regarding the patient's personality, so is the therapist's personality organized around either the fear of abandonment or the fear of engulfment along a continuum. Bar-Levav (1988) developed the concept of the fear of nonbeing in human development and described the centrality and dominance of fear in personality organization. He claims that the fear of nonbeing is experienced by every infant from the moment of birth and that it is registered in the infant's physiology. Ultimately every person's existence is based on avoiding the re-experiencing of that early panic. "Gaining power, real or imaginary, in order to undo the sense of vulnerability is the single, basic force at the root of all human behavior. The push away from fear or dread supersedes everything" (p. 324).

Furthermore, in this theory, as soon as the infant starts to discriminate externality from internal processes, the fear of nonbeing begins to differentiate and delineate into the fear of abandonment and the fear of engulfment. Both fears are elemental and profoundly influence every person's life. The fear of abandonment is based on every infant's premature physical separation from the mother at birth. Therefore, the developmental corollary of emotional separation is often fraught with panic and is difficult to achieve. The fear of abandonment is very common and is expressed by the person's need to be attached to others. Overcoming it "is hardly ever accomplished without pressure, because

separating goes counter to Man's tendency to follow the path of least resistance. It is, however, the major necessary step in the process of individuation, our becoming emotionally whole individuals, not merely detached parts of someone else" Bar-Levav, 1988, (p. 29).

The nature and influence of the fear of engulfment are equally powerful. The panic that one experiences with the fear of engulfment is similar to that experienced with the fear of abandonment but it is stimulated from the opposite direction. The person fears that his or her existence is in jeopardy unless he or she can immediately escape. The sense of being choked, swallowed, controlled, and manipulated by others is stimulated when a safe distance is not always maintained. "A basic protective readiness always exists to push away those who are experienced as coming too close. The fear of engulfment can be held in check as long as control is maintained of all relationships with others" Bar-Levav, 1988, (p. 40).

Therapists also must contend with these two fears. Therefore, it is important to consider that the frequency, intensity, content, and style of the therapist's interventions may not necessarily be a function of free choice but rather a function of the therapist's character adaptations to unconscious, irrational fear. Even one's theoretical persuasion may be more representative of these adaptations than of a thoughtful, fear-free search after scientific truth. It is important to recognize and to determine the degree to which the therapist's fears get activated in the group. This can be accomplished in part by answering such questions as:

1. Are the therapist's countertransference reactions unique to the group?
2. Is the therapist using the group to resolve or to act out his or her own conscious, preconscious, and unconscious feelings and wishes?
3. How is the therapist's therapeutic style or the therapist's activity level influenced by his or her fears?
4. Which irrational fears [anxiety] are activated and impact negatively on the therapist in the group setting. For example:
   a. Is he or she afraid of intimacy with men or women?
   b. Is he or she afraid of authority, power, or loss of control?
   c. Is he or she afraid of open, powerful expression of feelings?
5. What type of fear or anxiety dominates the therapist's own psychological organization, that is, the fear of abandonment or the fear of engulfment?

It is the task of every therapist to address such questions as an integral part of self-scrutiny with regard to his or her function in the group and in particular in the examination of the reasons for his or her failure in group psychotherapy.

FAILURES IN GROUP PSYCHOTHERAPY AT THREE DIFFERENT PHASES OF TREATMENT

Failures in group psychotherapy have been examined from perspectives of diagnoses, countertransference reactions, duration of therapy, and patients' difficulties in the group. It is probably more useful to look at the time of failures in group psychotherapy since they occur at different phases of treatment; the initial, the middle, and end phase of therapy. The literature suggests that groups function according to developmental stages. MacKenzie (1987) developed a model of five stages plus a termination phase, whereas Beck (1974) elaborated nine distinct stages. Alonso and Rutan (1984) developed a three-phase model based on object relations theory: each psychotherapy group evolves through the first stages, schizoid position, the second stage, paranoid position, and the third stage, depressive position. They recognized that much depends on "the therapist's capacity to encourage and tolerate this stage" and on whether "the therapist has been competent in allowing such a split and in containing the patient's worst projections" (p. 1378).

It is not the time clock that sets the boundaries between the three phases. Although distinctly different from each other, these phases are demarcated by flexible and permeable boundaries. The unique features that differentiate each phase will not be delineated here. However, it is clinically evident that there are clear differences between the initial, middle, and end stage of a long-term psychotherapeutic process.

A study of therapists' particular difficulties at the various phases can serve several purposes. It can help therapists who typically have difficulties at any one phase of treatment evaluate and address their fears more effectively. It can also help them to anticipate and prepare for future problems.

Failures at the Initial Phase of Treatment

Many failures at the initial phase of psychotherapy are based on the therapist's most primitive irrational fears and his or her adaptations

to them, which are often expressed in gross countertransference responses. These are grossly distorted responses in the sense that they are not the product of the burgeoning therapist–patient relationship. Although they may have been triggered by the patient's unique character, behavior, or psychopathology, they most likely emerge out of the therapist's own past life experiences.

At the initial phase of psychotherapy the whole future of and the responsibility for the patient's treatment lies before the therapist. At the same time the uncertainty and vulnerability of a fragile, emerging relationship is at its highest point. The therapist cannot gain comfort for his mistakes and errors "knowing" that the patient will be back next session. The relationship is just beginning to take shape and it cannot tolerate undue pressure. Everything is uncertain; the relationship is unsettled, the boundaries are ill defined, and the therapist has little realistic power in the fledgling alliance.

This state of affairs is quite similar in its affective components to the most primitive infantile stage of development. It is fertile ground for the most primitive fears of the therapist to emerge. The desperate, hungry, needy patient's efforts to merge with, cling to, and clutch the therapist are inescapable. The desperate, pushy, distrustful patient's efforts to attack, push away, and leave the therapist are palpable. Both can be threatening to the therapist. The former stimulates the primitive fear of engulfment and the latter the primitive fear of abandonment. Assuming a clinical posture and adhering to a professional attitude and known code of ethics is sometimes enough to contain even extreme anxiety within the therapist, but not always. The proper professional attitude functions as an artifical boundary, which helps the therapist temporarily contain his or her fears, although they most likely will emerge at a later date.

However, the influence of the therapist's irrational fear can be so global that it debilitates and has an adverse impact on both his or her professional and personal life. Reacting to such powerful primitive fears, the therapist is unable to lay the foundations for the necessary real relationship to anchor the patient. This author concurs with Greenson's (1978) understanding of the real relationship. By contrasting the concept of the real relationship with transference Greenson distilled two essential real-relationship elements: realistic and genuine. "There are two important meanings to the word real

Real means genuine and authentic; sincere, not synthetic. Real also means realistic. Transference is real in the sense that it is genuinely felt, but it is unrealistic. . . . Thus, real has at least these two different meanings: it means both genuine *and* realistic" (p. 363). Without a developing real relationship the anchoring of the patient will not occur and the therapist is doomed to fail.

Clinical Example 1

The patient, Mr. X, dropped out of therapy before the first group session. A man in his early 30's, he stared at me 15 minutes into the first session, just as I was taking his history, and told me to "get fucked." He then stood up and walked out of my office. I was stunned. Thinking about the patient later, I discovered that from the start I did not like him. I did not like his aggressive, challenging look, nor his pushy, harsh manner of speaking and his unkempt demeanor. I was jumpy, unsettled, and somewhat agitated by his demanding, intrusive manner. *I* had a problem right at the initial phase of therapy.

This was a prerelationship problem. It was a gross countertransference reaction. From the start I failed to make real contact and to develop a real relationship with him. I was instantly involved in my own unresolved fear of engulfment, and reacted to that rather than to the patient. I failed him, and in doing so, I failed.

Most of outpatient therapy failures occur in the initial phase of therapy—the first weeks or months of treatment. The real reason often remains hidden behind half-true claims of improper placement, financial difficulties, time conflicts, or technical mistakes in forming the therapeutic contract.

These failures occur primarily because the therapist's own unresolved primitive fears prevent him or her from forming a real relationship with the patient. Without a growing real relationship to anchor the patient while still in the initial phase, he or she will not be able to tolerate the stormy, affect-laden group psychotherapy process.

Clinical Example 2

A patient in her thirties, Mrs. B, disclosed in an individual session after her history was taken, that she really came to therapy because she "could hardly control her temper." She further stated that she

had often beaten her young son, and revealed that the department of social services had been involved. She really sought psychotherapy because of their recommendation. As a sensitive, eager, young therapist I placed Mrs. B in a group after several individual sessions. Within a relatively short time I encouraged her to speak about her reasons for coming to therapy. Mrs. B shied away from the real reasons but I pushed her to speak about them truthfully, which she soon did. Not long after she revealed her secret, group members responded with shock and with open anger. It was not really surprising even to me, on later reflection, why Mrs. B did not return to therapy. All my efforts to bring her back have failed.

In retrospect I realize that I acted out my own rage at my hysterical, overintrusive, and often absent mother. My own unresolved fear of abandonment was triggered as well as my infantile rage at mothers who abuse their sons. I responded to my own irrational needs rather than to those of my patient, unconsciously using the group as my punitive agent. I pushed this frightened, shame-filled, guilty woman to speak about her secret prematurely, before I formed a real relationship with her. A solidly formed real relationship could have protected, defended, and kept her in the group, even at moments when I was wrong.

Therapists whose primitive, irrational fears have not been worked through will fail at the initial phase of therapy. Their countertransference reactions and distortions will be at an all time high at that point, preventing them from forming a real relationship to hold the patient in treatment. Therapists who fail in their therapeutic efforts at the initial phase often blame "the system" with righteous indignation, or the patient, but rarely themselves. They tend to hide behind a "therapeutic contract" and deny their own shortcomings and their own emotional difficulties. Some even know that something went awry in the treatment, but even so they can tell themselves that the patient was too sick to stick with the contract. They accept too easily such claims as "I do not have enough money," or "I don't have the time," or "something was not right in the negotiations at the beginning of therapy."

There are as many examples of failure at the initial phase of psychotherapy as there are patients who left treatment after only a short therapy encounter.

Failures in the Middle Phase of Treatment

If the therapist is not burdened by unresolved, irrational fears, there will be no gross countertransference reactions and the patient is likely to get to the middle phase of treatment. The foundations of a solid real relationship have been established. As therapy progresses previously hidden dependency feelings usually surface in such a setting as the repression within patients lessens. Early infantile yearnings—preverbal hunger associated with preverbal fear and rage—are the central themes of the psychotherapeutic process at this phase of treatment. Patients begin to depend more openly on the therapist and on their group. Because "both the fear of abandonment and the fear of engulfment normally co-exist in every person" (Bar-Levav, 1988, p. 332), at this phase of treatment both fears may also be stimulated in the therapist. But depending on the therapist's earliest life experiences and the particular patient's affective expressions, one of these two fears will dominate the therapist's interventions at this phase of treatment.

At the middle phase of properly conducted therapy the patients feel safe enough to demand more, and they find room to express openly primitive, dependent wishes. Patients' open demands for gratification of infantile wishes obviously must remain unrewarded, leading to an open expression of rage and fear. The level of yearnings expressed in relation to the therapist as well as the number and intensity of regressive episodes increase at this phase, often activating the therapist's fear of engulfment. Expressions such as: "I want you to hold me," "I want more from you," "I want to be more involved with you" would be thwarted even by unconscious fears of engulfment of the therapist as if he or she were saying "stay away from me," "this is too much," "I can't give more." Therapists with a predominant fear of engulfment will have a most difficult time with patients with a predominant fear of abandonment. These therapists will be frightened of their patients and will not be able to tolerate their powerful, repeated, persistent demands.

Clinical Example 3

A patient in her early 40's who had been in therapy for 5 years began to express her powerful infantile, preverbal yearnings by acting out.

She asked me to call her between sessions, demanded an exclusi involvement with me, wished to see me more frequently, wanted n to answer her repeated phone calls, and even to meet her outside therapy. My unwavering proper therapeutic stance (individual a group sessions only in my office, no dates, dinners, or social calls wi patients), further provoked both her preverbal hunger and rage. S tried to involve me by increasing the frequency of her phone calls a by her hysterical behavior, which reached a dangerous level, culmina ing in a suicide attempt. In my efforts to help myself I presented h in many individual and group supervision sessions. I spoke about h and of my feelings about her with my colleagues. In my own analys at the time I remember a recurrent nightmare associated with he that of fighting a boa constrictor that was choking me.

Her explosive outbursts of rage followed by expressions of hel lessness and despair eventually frightened me and her group member Several months after her suicide attempt, when she announced he plan to move to California, neither I nor her group members made serious enough effort to dissuade her, to challenge her decision, t confront her, or to "hold" her. She left therapy. Because of my ow fears of engulfment I was unable to hold onto her. Sadly, despite m many efforts to resolve my own difficulties with this patient I was no able to help her once she reached the middle phase of her therapy.

At this middle phase of treatment with a solid foundation of real relationship in place, patients with predominant fear of en gulfment will verbally attack, criticize, demean, and devalue the thera pist, the group, and the whole therapy process. As patients progres in this phase they may even express their fear of engulfment by threat ening to leave therapy, and some actually do so. Such distancing ges tures, which are verbally aggressive and hostile, often stimulate th fear of abandonment in some therapists. They typically defend agains it by clinging to their patients, which obviously dooms the entire thera peutic effort.

Clinical Example 4

Mr. B, a 40-year-old salesman, suffered from severe fear of en gulfment. After 4 years in individual and group psychotherapy he kep insisting that, although not finished, he was about to leave therapy.

As his repeated threats were worked with, deep hurt and powerful yearnings emerged, and his fears subsided. He settled down and continued to attend the group sessions. As soon as intense feelings of intimacy would arise in the group he would panic and proclaim yet once again that therapy had not helped him, that he did not want to hear other people's problems, and that he planned to leave therapy. Over time, and after many such provocations and threats, my own fear of abandonment was re-activated. These were the emotional residue of my feelings as an infant who was repeatedly left alone by his overburdened, disinterested, and busy mother. I did not normally feel such fear, because like others, I too defended myself against the emergence of my own fear of abandonment by clinging and by other character defenses.

To ward off my increasing anxiety and to reestablish an emotional equilibrium, I became increasingly impatient and angry at Mr. B. Finally I accepted his plan to leave psychotherapy. Not having sufficiently resolved my own fear of abandonment, I could not help him enough with his tremendous fear of engulfment. At his final group session, another patient angrily challenged Mr. B and said, "So, is this your last group? Good! I hope so!" I didn't intervene and didn't help Mr. B reconsider his decision to leave.

Other failures occur when the patient is kept in psychotherapy for "too long." The therapist, his or her own fear of abandonment unresolved, holds on interminably to patients who suffer from fear of engulfment. The patient pushes away the therapist a little at a time, while the therapist responds by repeatedly pursuing the patient. A circular, pathologic, back and forth dance of pushing away and drawing near continues for many years. Such treatment also constitutes a failure.

Failures in the End Phase of Treatment When the Therapist's Main Fears are of Engulfment

Therapists who suffer from severe fear of engulfment can never help their patients reach the last phase of therapy. At this phase, real intimacy develops among group members as well as between them and the therapist. As group members get closer, trust each other more, and deal more openly with intimate material, the therapist who suffers

from engulfment fears will interfere with, or stop, the process. He or she will not be able to tolerate the closeness. Such a therapist cannot allow real trust and intimacy to flourish. Hiding behind the concept of therapeutic neutrality, such a therapist will not let himself or herself be known as a person. He or she will rationalize that self-disclosure is not necessary for the development of real intimacy. Patients then leave therapy unfinished, with at least a vague sense that their therapist was not really trustworthy, not there, unreal, unfeeling, phony, not involved enough, and disinterested in them as human beings.

The therapist's fear of engulfment is often expressed in very subtle ways. The therapist may rationalize that the group has resolved most of its conflicts, and members are now intimate with each other. Therefore, the therapist should really stand back lest he or she continue to promote unrealistic dependency.

In the last phase of therapy the therapist cannot assume a stance of neutral observer. The patient needs to engage and be engaged and get to know the therapist as a real person. At this phase patients talk about themselves in a different way and on a deeper level. Many distortions have been worked through and group members interact with greater trust, intimacy, and mutuality. If the therapist "hangs back" patients will not want to expose the more shameful aspects of themselves. They sense that the therapist's "neutral therapeutic posture" is really the manifestation of the therapist's personal difficulties in forming a real relationship rooted in the fear of engulfment.

Failures in the End Phase of Treatment When the Therapist's Main Fears Are of Abandonment

After testing the therapist for many years, the patient nearing the end of therapy is finally able to experience the therapist as a firm, trustworthy, limit-setting, holding, real person. The patient's preverbal yearnings no longer find expression in hysterical acting out or through self-destructive behavior. Panic subsides and anxiety gives way to wishes for real intimacy (not to be confused with social or sexual interaction), which should develop between the patient and the therapist, and between the patient and his or her group members. This is a time when the patient's thoughts, feelings, and plans about

leaving therapy emerge. The therapist must also entertain thoughts of separation: "We're getting close to the end."

Primitive, infantile yearnings relating to early separation from mother may get reactivated in the patient. But a final, inevitable separation after a deep involvement with a patient over several years of struggle may be not only welcomed but also feared by the therapist. Some of the therapist's own unresolved fear of abandonment may now get stimulated. As a result, the therapist may unwittingly foster the patient's reemerging wishes for real dependency rather than challenge them (real dependency is not real intimacy). The therapist may infantilize the patient, and discourage him or her from leaving therapy, perhaps indirectly and/or unconsciously. Consequently, the patient's engulfment fears may be reactivated, precipitating a crisis that could propel the patient to end therapy unfinished.

Clinical Example 5

After having been in treatment for over 10 years, Mr. A left therapy precipitously. At the beginning of treatment, as part of his therapy contract with me, Mr. A agreed that he would discuss every decision to leave therapy in three consecutive group sessions. The therapeutic purpose is to provide enough time for the patient to examine his or her motives and to not act out by leaving impulsively. Even though Mr. A followed the letter of the contract and told his group of his intentions to leave, he never reconsidered his position. He was determined to leave and all my efforts to help him reopen the issue were unsuccessful.

I could easily explain Mr. A's abrupt leaving based on his psychodynamics and psychopathology, but what was difficult for me to see was my own part in it. But now, in retrospect, my relationship with him is becoming clearer. I loved him too much for my own reasons, and I was too proud of the changes and gains he made in his life. My predominant fear is that of abandonment, and I am sure therefore that somehow, at the end phase of Mr. A's therapy, I must have held on to him for my own needs. He must have experienced my clinging-like behavior and that rekindled his fear of engulfment. His sudden departure was in large part a healthy response to my wrong interventions. However, he has neither called nor sent me a card since, because

his own fear of engulfment and perhaps his anger have not yet sufficiently diminished.

CONCLUSION

To advance our knowledge we must dare to examine our own contributions to failures in psychotherapy. It is in fact personally and professionally freeing to admit to one's errors openly and to discuss them with colleagues. My own failures in psychotherapy cover a range, from the patient who left 15 minutes into his first session to the one who left unfinished after 10 years of treatment.

Such therapy outcomes are probably not uncommon. I regard myself as a conscientious, competent, and serious therapist, but hardly a perfect one. How do I help myself with my failures in psychotherapy? If one accepts the clinical, professional approach espoused here, which places responsibility for failures on the therapist's shoulders, it is imperative that:

1. Each therapist has his or her own personal, competent, intensive, long-term psychotherapy.
2. Each psychotherapist has an ongoing, regular individual and group supervision.
3. Each therapist utilizes a theoretical framework and a therapeutic system that makes scientific sense. The therapeutic principles discussed in this article and the recognition that the fear of abandonment and the fear of engulfment are real forces that directly impact the therapeutic process, offer the therapist a beginning theoretical framework to apply to the process of psychotherapy.
4. Each therapist is professionally involved in a support community of colleagues. Such a community should live by mutual respect and adhere to the principle of challenging each member's fears and character defenses as they relate to therapy with patients. In a safe, confronting, colleagial environment the therapist is able to speak freely about his or her feelings and thoughts. This support system is extremely important as it is impossible to conduct effective, long-term, intensive combined individual and group psychotherapy all alone.
5. No therapist should isolate himself or herself. Rather, therapists should participate in and have full, open, and rich personal, social, and communal lives.

I also help myself with my failures in psychotherapy by knowing that some patients are so very ill that despite my knowledge and all

my best efforts I cannot cure them. I also hold onto my belief that a patient who has had even one session with me might have been helped on some level, even if just a little. The rabbis of old said: "Any person who has saved even one soul, is as if he had saved the whole world and any person who has destroyed even one soul, is as if he had destroyed the whole world." I use this as my personal motto; it allows me to carry on.

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Discussion of "Failures"

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There is much to applaud and much to quarrel with in the foregoing paper. Natan HarPaz takes the useful stand that the outcome of group therapy is determined solely by the therapist and that the therapeutic vehicle is the therapist–patient interaction. The vicissitudes of that interaction are attributed to the polar fears of abandonment and engulfment. HarPaz rightly emphasizes the professional responsibility of therapists to scrutinize their interactions with patients, to refrain from blaming patients when therapy stalls or fails, and to thereby detect and correct avoidable technical errors. Ultimately, however, HarPaz cannot resist stating that some patients are just too sick to be helped.

HarPaz's underlying premise is that therapy fails because the therapist does not scrutinize himself adequately or fails to detect that the patient is actually untreatable. His premise leads to the erroneous conclusion that any patient who is not *un*treatable is treatable if the therapist has enough self-awareness.

Not so. Explanations of the success or failure of group psychotherapy must include the following considerations, which I have presented at greater length elsewhere (Weiner, 1982, 1984a, 1986):

- *What patient*? (Who is the patient as a person?)
- *What problem*? (Is the presenting problem a disease or an emotional state?)
- *What goal*? (What does the patient want from therapy?)
- *What group*? (What is the type of group therapy [Weiner, 1984b]? What is the group composition? What is the phase of the group?)
- *What therapist*? (Who is the therapist? What skills does the therapist have?)

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- *What therapist goal?* (What does the therapist want for the patient?)
- *What circumstance?* (What is the motivation? What are the conditions?)

HarPaz's unstated further assumption is that the self-aware group leader prescribes an appropriate treatment, that the patient is interested in that kind of treatment and capable of cooperating with it, and that the therapist has the technical expertise to carry it off. Unfortunately, awareness of one's own dynamics and transference/countertransference issues is not a substitute for diagnostic acumen or technical expertise. A therapist's ability to understand his own or the patient's own dynamics is also not equivalent to the therapist's ability to treat that particular patient at the particular time.

HarPaz's treatment model is long-term individual therapy combined with long-term experience in a heterogeneous, open-ended long-term group; both aimed at recognizing and resolving the psychological conflict between fears of abandonment and engulfment. In this medium, patients are expected to express intimate longings without acting on them or regressing in the face of them. That is a tall order, especially in a medium as difficult to modulate as group therapy.

Let us turn to one of HarPaz's case examples and examine it from the broader perspective I have proposed. Mrs. B, whom I shall call the child-abuser, dropped out of her group, possibly prematurely. This woman, admittedly unmotivated for treatment, dropped out when pushed to disclose behavior that shocked and angered group members. That she dropped out is not surprising. She was probably ashamed and humiliated and may have felt betrayed. But why was she placed in a heterogeneous open-ended group? She might have had a better outcome (or at least a better chance to deal with her most pressing problem) had she been placed in a short-term homogeneous group of child abusers that focused on self-control, with long-term expressive therapy reserved for a later time and stronger motivation. In this case, the failure was failure to recognize the most appropriate treatment for the patient. In a child-abuser group, Mrs. B's problems would have tied her to the other members instead of alienating her from them. HarPaz suggests that had he shielded Mrs. B longer, she might not have dropped out. But had he continued to help her avoid discussing the problem behavior, he would have been tacitly agreeing that it should be kept secret, and her sense of betrayal would have

been even greater when it eventually became necessary to press her to deal with it. HarPaz did the right thing, but in the wrong group.

As a second example, let us consider Mr. B, who did not want to hear others' problems any more, after having worked in group and individually for 4 years. He repeatedly threatened to leave the group and was repeatedly induced to stay on the basis that he had not worked out his fear of engulfment. Finally, the patient left, following an angry remonstrance by one of the other group members, and HarPaz did not try to dissuade him. Viewed from another standpoint, HarPaz and the patient had different goals for treatment. The patient wanted to escape his fear of engulfment and HarPaz wanted him to face it. Why not allow him to drop from group and continue individual therapy? Why give the patient the impression that there was something terribly wrong because group therapy was not a comfortable medium for him?

Awareness of intrapsychic dynamics and transference/countertransference issues is good. The negative aspect of an exclusive focus on intrapsychic and transference/countertransference issues is that it ignores other, often overriding issues. Does the patient fit into the group to which he or she was assigned? Or was the patient assigned to that group because that was where the therapist had an opening? Does the treatment fit the patient? Patients with schizophrenia would hardly fit a model of group/individual treatment with a goal of resolving intrapsychic issues. There is no consideration that different types of psychopathology may require different treatment.

I propose to expand HarPaz's point of view in the following way. Assuming that the therapist has made the right diagnosis, has prescribed the right treatment, and has the technical expertise and the right group (and moment in the group's life) to carry it out; and that the patient is willing and able to work in the way and toward the goal that the therapist proposes, *then* it is most appropriate to examine the therapeutic relationship and its vicissitudes to deal with a stalemate or a negative therapeutic reaction in group therapy.

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Discussion of "Failures"

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It is a welcome opportunity to comment on Natan HarPaz's thoughtful article addressing the issue of the therapist's contribution to treatment failure. I concur with HarPaz about the central role played by the therapist in the outcome of treatment, and I appreciate his candor and openness in describing personally the impact on treatment of the therapist's fears of engulfment and abandonment. As a profession, we often learn most about successful treatment from the study of our failures.

HarPaz's thesis addresses the therapist's contribution to the process of effective therapeutic engagement, and in my view, at another level, hubs around the issues of boundaries and boundary maintenance within the therapy. As he points out, therapists are often too ready to blame the patient for the failure of treatment rather than to examine honestly their contribution, at the level of initial consultation, the middle phase of treatment, and the termination phase. This discussion will focus on certain considerations regarding leadership, boundaries, aspects of countertransference with a particular focus on projective identification, and the contrast between conjoint group and individual therapy in which two different therapists concurrently provide the individual and group therapy, and HarPaz's preferred model of combined therapy in which a single therapist provides both treatments concurrently.

A comprehensive review of the effects of leadership on negative outcomes in group psychotherapy reported by Dies and Teleska (1985) documents that a negative therapist–patient relationship is frequently the basis for therapeutic deterioration. This is particularly so when there is an apparent lack of positive regard on the therapist's part, or the presence of frank therapist hostility with aggressive confrontation of the patient, reflecting a lack of respect for the patient's individual needs or

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vulnerabilities. Similarly, therapists who appear to be at the extremes of either emotional stimulation or executive function within the group are less effective and are associated with more frequent treatment failures and casualties. Excess emotional stimulation may be reflected in the therapist's heightened subjectivity within the treatment, either through explicit excesses in self-disclosure, or through the predominance of the therapist's personal needs over those of the patient.

HarPaz comments on the underreporting of the therapist variable in treatment failure, and his article certainly succeeds in drawing attention to this effectively. My impression in reading this article, however, is that he is stretching this point to illuminate it, to challenge the propensity to blame the patient when treatment fails. Treatment failure, defined in this article as the patient's premature ending of treatment, is often best understood in systemic fashion, as a question of fit, and as a product of the equation of the Patient X the Group X the Therapist variables (Roback & Smith, 1987). A concurrence of factors that results in an impasse of failure in one equation may be treated successfully in another equation. HarPaz's emphasis on the therapist's fear of engulfment or abandonment obscures the systemic view by elevating the importance of the therapist's contribution, in particular as it may be rooted in the therapist's early life experiences. He suggests it is the therapist's distortion and "not the product of a burgeoning therapist/patient relationship. Although they may have been triggered by the patient's unique character, behavior and psychopathology, they most likely emerge out of the therapist's own past life experiences." If that is so then these fears are always on the verge of activation, and this then shifts the emphasis on remediation from consultation and supervision, to further personal therapy for the therapist.

Gutheil and Gabbard (1993) focus attention in timely fashion on the issue of the various treatment boundaries that must be maintained for ethical and successful therapy and the integral link between boundary maintenance and countertransference. Therapists must be alert to any crossing of boundaries reflected in a range of areas including roles, time frame, money, gifts, self-disclosure, and physical contact. They recommend that the therapist be able to identify any deviation from his/her normal practice and additionally be able to offer a therapeutic rationale and an understanding for this boundary crossing that could withstand the scrutiny of an objective colleague. The therapist's

need for security, if unscrutinized may translate itself into a crossing of boundaries, in which the therapist's needs dominate the treatment setting. I agree fully with HarPaz's belief that the therapist may resist self-scrutiny and in doing so may blame the patient and deny his own contribution to the treatment failure. It is the inability or unwillingness to scrutinize oneself that leads to therapist behavior that perpetuates patient difficulties by aggravating the transference–countertransference vicissitudes, induced by the patient's defenses and utilization of mechanisms such as projective identification. However, in this regard it may be preferable to conceptualize countertransferential difficulties as a "joint creation" (Gabbard, 1993) of the patient and therapist, rather than considering it as being shaped predominantly by apparently unresolvable, primitive anxieties within the therapist, as Mr. HarPaz suggests.

Effective conduct of psychotherapy resides in the effective utilization of one's countertransference. Supervision and consultation are essential in this regard in helping to create what Mollon (1989) describes as a "space for thinking," into which the therapist is able to enter in order to perform the tasks of self-scrutiny and working through. The therapist must always monitor his own contributions to his countertransference, including his past relationships and experiences, as well as the aspects of countertransference that are evoked by the patient's particular behavior or dynamics. It is a source of valuable diagnostic and therapeutic information and the cornerstone of accurate empathic resonance. It can include the therapist's normal human reaction to what the patient induces, and in addition, specific reactions that the patient evokes in the therapist by virtue of what gets projected onto the therapist or into the therapist. The therapist may learn a great deal about the patient's internal world by his reactions to the patient if he is able to direct his free-floating attention to his own emotions and thoughts. Interpersonally, the therapist may get hooked and begin to respond in an emotionally alive fashion to the patient's interpersonal behavior, but then the therapist must be able to regain his objectivity, in order to get unhooked from the enactment, or recapitulation of the patient's difficulties (Leszcz, 1992).

It is only through the therapist's capacity to know himself and be able to detect deviations in his normal therapeutic behavior either behaviorally, verbally, through associations, or fantasies that the thera-

pist is able to get unhooked and provide not a complementary recapitulative experience, that confirms the patient's fundamental, pathologic paradigms about human relationships, but, a concordant one that deepens understanding of the patient's contributions to the interaction, and promotes growth and change. The patient has the right to expect that if he or she brings himself fully to the treatment, in characteristic fashion, that the therapist will be able to aid in working through rather than engage at the level of recapitulation and reverberation.

Certainly, some aspects of the patient's behavior will have a different impact on different therapists, and in particular with projective identification, certain patient projections will fall on more or less fertile soil within the therapist. Projective identification can be conceptualized as both a defense and an interpersonal interaction, in which the unconscious objective of the projector is to transfer an unacceptable and frightening internal experience into the object, but with the unconscious hope that the object will be able to detoxify and permit reintrojection for the patient of a less dangerous, more neutralized version of the original projection (Gabbard, 1993). I find this a particularly helpful concept in dealing with the kind of difficulties that arose in the second case described by Mr. HarPaz. Could such a model have helped protect this patient from inducing the therapist and the group to act out sadistically toward her, reflecting her own shame and guilt about her abusiveness, and her own propensity to victimization?

Many patients referred for group psychotherapy, in particular those with characterological difficulty and those with significant interpersonal distress, experience significant difficulties in the area of separation–individuation with associated fears of abandonment and engulfment. HarPaz succeeds in recognizing the countertransference problem, but in each of the cases he describes, it is a post facto explanation of the treatment failure. Does this infer that the intensity of this problem is such that it can only be recognized after the fact, once therapy has stopped, and the patient–therapist relationship has ended? Are there situations in which the recognition of these issues within the therapist are translatable into therapeutic success that avoid treatment failure or resolve a therapeutic impasse?

In related fashion, I question somewhat Mr. HarPaz's contention that the entire responsibility for the patient's treatment lies before the therapist and that the therapist is at the epicenter of treatment. This

premise may unduly amplify the therapist's anxiety about the responsibility he has for the patient, which may then translate itself into amplified concerns about boundaries and exacerbate concerns about abandonment or engulfment. In the group therapy setting, in particular, this may diminish the impact of the group and the importance that the group plays in the treatment, relegating it as secondary to the "real" work of therapy that occurs in one-to-one therapy. Furthermore this model decreases the sense of the "joint creation" of the transference–countertransference and underplays the importance of collaborative exploration within the therapy. It is evident that it takes a significant amount of courage on the part of the therapist, as demonstrated by Mr. HarPaz, to perform this self-analysis and self-scrutiny. The therapist may feel even more willing to perform this self-scrutiny and to utilize consultation and supervision, if he views these powerful fears as an intersubjective transaction rather than as a reflection of personal, intractable disturbance.

An additional consideration is the role played by combined treatment (Wong, 1983). In this model, the therapist's responsibility is indeed heightened as the therapist provides both the individual and group therapy for the patient. The additional interface between patient and therapist, coupled with confusion that may arise about what clinical material belongs where, and the timing of its disclosure may aggravate these boundary concerns. In some instances, the therapist and patient form a subgroup in which they alone have information that others in the group do not yet have. This boundary around the subgroup may intensify their interaction and stimulate regressive pulls on both the patient and therapist exacerbating concerns about abandonment or engulfment. As an alternative to combined therapy, conjoint therapy, in which a different individual therapist and group therapist collaborate together, may achieve the same salutary effects of combined treatment, while diluting the intensity of the transference and diminishing the central dependence and focus of the patient on a singular therapist (Ormont & Strean, 1978). Conjoint treatment requires a solid, open, and trusting working relationship between the two therapists. In that situation, it effectively decreases the therapist's undue responsibility for the patient, although at the same time it may decrease patient regression and distortion through the provision of multiple settings, multiple transferences, and multiple objects for relat-

edness. It also may provide collegial support to the therapist, and ongoing peer consultation to serve as an additional vehicle for the identification of countertransferential reactions (Ormont & Strean, 1978).

I believe that Mr. HarPaz makes a valuable contribution to the literature with his exposition of the therapist's responsibility for treatment failures. An effective therapist is one who is able to examine his own reaction, behavior, psychodynamics, and fear in order to emancipate himself within the therapeutic relationship to be maximally effective and to spare the patient the burden of his unresolved issues. HarPaz recommends that in order to achieve this objective, the therapist be well anchored and supported both personally and professionally, and have access to sources of satisfaction and gratification from many areas in life. His conclusions are both clear and sound.

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Response to Weiner and Leszcz

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I welcome the critical comments of Drs. Myron Weiner and Molyn Leszcz. It has been amply demonstrated that there is a relationship between the therapist's personality and the therapeutic process (Angelos, 1977; Barron, 1978; Herron, & Sitkowski, Ginot, 1986; Schwartz, 1978; Strupp, 1978; Tremblay, Herron & Schultz, 1986). It has also been noted for some time that a relationship exists between therapist variables and therapy outcome (Beutler, 1991; Luborsky et al., 1986; Parloff, Wakson, & Wolfe, 1978; Strupp, 1978). However, what has not yet been adequately addressed in the field is the tremendous impact of the therapist's unresolved irrational feelings on the therapeutic process. By personalizing "Failures in Group Psychotherapy," I endeavored to emphasize two critical issues. First, *failures* in group psychotherapy is not as neutral a concept as therapy *outcome* and the clinical vignettes underscore that the lives of patients are at stake when failures occur in psychotherapy. Second, it places the onus of guiding the therapeutic process where it belongs, squarely on the therapist's shoulders.

Both Weiner's and Leszcz's thoughtful discussion of "Failures in Group Psychotherapy," underscore the often avoided central theme—the critical role of the therapist in the outcome of treatment. The inherent difficulties in effecting change in the therapist often divert our attention from the therapist to other factors that influence the therapeutic process. It is frightening, painful, and difficult for therapists, as it is for nontherapists, both to recognize their own unrealistic feelings and alter their characteristic way of handling them. Because the therapist is the instrument of change (Bar-Levav, 1988) therapists must realize that their unrealistic fears of abandonment and engulfment limit their freedom and ability to do that which is often necessary to cure their patients. The absence of the therapist's awareness in and of itself is obviously not the sole cause for failures in group

psychotherapy. Neither is the presence of the therapist's awareness the sole cause for success.

Weiner's variables of accurate diagnosis, therapist's skill, timing and group composition are basic well-known factors (Friedman, 1989; Yalom, 1975), which obviously affect the outcome of group psychotherapy. My article demonstrates that the therapist's unresolved fears are often so powerful that they impact the therapist's perception and function across all of these variables. Namely, a therapist with unresolved fear of abandonment would assess "what patient," "what problem," "what group," "what therapy goals," and "what circumstances" differently than one with unresolved fear of engulfment. Each would yield a different "outcome" and would contribute differently to success of failure in group psychotherapy. In addition, to view a patient exclusively from an intrapsychic transference/countertransference paradigm would be distorted, unreal, and harmful.

For instance, although a different group might have helped Mrs. B, the child-abusing patient, moving the patient does not address the issue of the therapist's fear, which might come up in similar circumstances at different junctures in therapy. Similarly, even the goal of psychotherapy, which must be clear to the therapist at all times, is often mediated by the therapist's unresolved irrational fears. Although Weiner's variables are important to consider, they obfuscate the difficult task at hand. To access the therapist's fear continuum one must focus on the therapist's feelings and not be distracted by conscious or unconscious pulls to attribute success or failure to external variables.

Leszcz's comments on the systemic understanding of treatment failure underscores the "concurrence of factors that results in an impasse or failure." All the factors are not of equal valence or weight in the therapy equation. My emphasis on the therapist's variable does not ignore the system but alters it by amplifying the importance of the therapist variable. Leszcz correctly recognizes that the emphasis on the therapist implies that "these fears are always on the verge of activation." This is true. Therefore, personal, intensive, long-term psychotherapy is a prerequisite for anyone who endeavors to undertake intensive psychotherapy with patients. Only after the therapist's own irrational abandonment and engulfment fears have been sufficiently worked through in his or her personal psychotherapy is the therapist honed enough to do the work fully. Consultation and super-

vision are obviously not a substitute for personal therapy (Salvendy, 1993); they only alert the therapist to the lingering residues of fear of abandonment and engulfment, but do not provide the opportunity to work them through. Co-therapy, regular supervision, and collegial confrontations are all necessary for the therapist to do his or her work. They help maintain the vigilant perspective required to properly assess and correct the adverse impact of the residues of the therapist's irrational fears. They also provide a forum for continued exercise and strengthening of the therapist's boundaries of the self.

I support Leszcz's position that the therapist's countertransference can be a "source of valuable diagnostic and therapeutic information and the cornerstone of accurate empathic resonance," but only after the irrational abandonment and engulfment fears have been sufficiently worked through. It is then that the therapist can be truly effective, listen to his or her countertransference process, and utilize it creatively to affect therapeutic change.

I also agree with Leszcz that combined therapy places inordinate demands on the therapist and may result in amplifying the therapist's fear of abandonment and/or fear of engulfment. Therefore, it is imperative to work with a co-therapist in the group (Bar-Levav, 1988). The subject of co-therapy is beyond the scope of this article, but it must be stated that failures in group psychotherapy are not necessarily ameliorated by using a co-therapy team. The unresolved irrational fears of a co-therapist may confound the problem and introduce treatment failures due to, for example, unconscious collusions and split transferences between patients and therapists and transference reactions between the co-therapists themselves. However, when both therapists have essentially worked through their own irrational fears, they can have a solid, open, real, trusting relationship with each other, which is necessary to conduct proper co-therapy. They can then be subjects of "multiple transference and multiple objects for relatedness" for their patients as well as provide collegial support for each other.

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