

Preface

I have become a preface reader. It personalizes the work, not unlike getting to know the players on a team. The more one knows about the issues the author is struggling with, the easier it is to follow him/her along. For those of us in St. Louis, watching the Rams offers more opportunity for meaning than, say, watching Buffalo. So it is with books.

Also, it is the best place to get a quick summary. The preface to *Group Therapy* touches all the major issues of group, in eight pages or less. Thus one starts with a map and works down to the street corner, rather than *visa versa*. It aids focus.

Yalom asks:

“What if marketplace considerations demanding quicker, cheaper, more efficient methods act against the best interests of the client? And what if “efficiency” is but a euphemism for shedding clients from the fiscal rolls as quickly as possible? And what if these diverse market factors force therapists to offer less than they are capable of offering their clients?”

These are not rhetorical questions. Actually, they are not even questions. They are politically correct ways of stating facts. And they might lead to a problem that could dog us all through this study. He continues:

“If these suppositions are true, then the requirements of this revision become far more complex because we have a dual task: not only to present current methods and prepare student therapists for the contemporary workplace, but also to preserve the accumulated wisdom and techniques of our field even if some young therapists will not even have immediate opportunities to apply them.”

If this dual task interferes with presenting the best treatment options then perhaps we would do better to revert to the fourth edition of this book. Evolution is not directional. It is opportunistic. There is no guarantee things are moving to something better. In a brutal society ethical behavior can get you killed. Survival of the fittest is not necessarily survival of the best.

And since it is true that he who pays the piper calls the tune, short term, problem focused, limited goal therapy might overgrow the field. That does not thereby improve the garden. This metaphor is not hard to visualize.



Speaking of evolution, man continually opposes it. Rather than adapt to the environment as in evolution, man adapts the environment to him. Complex society is due to human intervention. If there is a plan it works through us. Managed care mandates short term problem-focused treatments. Yalom and your editor think this might be economically adaptive for therapists, although not necessarily beneficial for group members. Truth and cost cutting do not typically travel in pairs.

We take things for granted when we grow up in a system, but that might not be wise. For example, financially, it is insane for banks to lend out thirty dollars for every dollar deposited with them, however they have done so and now are bankrupt. We just accept that as how business is done. Now with the disaster everyone is supposed to “pull together” to fix the problem. This is heads they win, tails we lose. Also, today a third party becomes involved in almost all medical payments. It did not used to be that way. Whatever happened to direct payment for service? Medical treatment is not free anyway even with insurance, and once the companies get into the chain they call the tune. They should probably be left out whenever possible. One could pay for group therapy without insurance. This is one medical area that remains cost effective. We can comfortably run twenty-five people in a group and at twenty dollars a piece that group could hire any therapist it wishes. Do the numbers any way you want, but a therapy session will still cost less than a night at a Cardinal game. If someone does not wish to pay this amount they will not benefit from treatment anyway.

The Veteran’s Administration was one of the few remaining medical systems that did not limit the frequency or length of group therapy. Yet even they began moving to a short term format, an exercise they had to recently reverse. In my opinion that reversal was at least in part a reaction to the St.

Louis veterans talking to politicians. These veterans were very active in expressing their opinions about the value of the therapy they had received, and they did so with an energy and candor that was hard to dismiss. But the VA has a different mandate than the private sector and perhaps can be more independent in these issues.

Yalom lists the great variety of groups available today, although he has a favorite, which is the model he presents throughout the book:

“The prototypical model is the intensive, heterogeneously composed outpatient psychotherapy group, meeting for at least several months, with the ambitious goals of both symptomatic relief and personality change. Why focus on this particular form of group therapy when the contemporary therapy scene, driven by economic factors, is dominated by another type of group—a homogeneous, symptom-oriented group that meets for briefer periods and has more limited goals?”

The answer is that long-term group therapy has been around for many decades and has accumulated a vast body of knowledge from both empirical research and thoughtful clinical observation. Earlier I alluded to contemporary therapists not often having the clinical opportunities to do their best work; I believe that the prototypical group we describe in this book is the setting in which therapists can offer maximum benefit to their clients.”

If this is true then seek the best, either through the economic food chain, or if that is not possible, then on your own. And if the system no longer trains this type of therapist, learn it yourself. Do not assume that latest means best.

Managed care embraces group as the treatment modality of the future. Cost containment is a mandate of managed care. That is not necessarily a bad thing. Resources are limited. Still, you can be sure that cost is one of the things the insurance companies like about group therapy. We could address twenty-five people in a two hour group that would take three days to handle with individual sessions. But the more cost effective a treatment is the less one needs to insure against it. No one buys insurance to protect against flat tires. A group of even ten people could go out and hire a therapist of their choosing at a modest cost to the individual members—if such a therapist is available. I am just saying that when it comes to group therapy it should be possible to choose. One need not simply take what is offered.

Yalom goes on to stress how the scientific method separates other aspects of medicine from psychological treatment. Today, evidence-based data trumps clinical experience. Mental health is not happy being the step child of the medical field. It did not make such frenetic attempts to appear scientific sixty years ago. Psychoanalysts simply postulated mental agencies and people treated these constructs as physical entities. Psychoanalysis was the gold standard of mental health treatment through the first half of the twentieth century, and Freud did not carry out one experiment. His work was all clinical-deductive. No one worried much about that at the time. What changed?

Perhaps we have simply become metaphysically more sophisticated; in fact, the opposite appears more likely. Everyone is out now gathering empirical data, putting a number on anything that moves. Few stop to consider the nature of things. The change is probably economic. Forty years ago Blue Cross would pay for an entire psychoanalysis. This could be ten years



of treatment as often as six days a week. That could not continue, and it did not. The mantra now is “show me the evidence”. Medical insurance will pay for a broken bone but not a split self. Physical is objective; mental is subjective. How does one compensate for anguish when the only evidence of it is personal testimony? This presents the patient with a moral hazard and the insurance com-

pany with potentially unlimited cost. So psychiatry has fought an uphill battle in recent years for equal compensation in treatment. But mental and physical are not equal and differences must be noted, although suicide is just as terminal as any physical disease.

The problem lies in the mind/body dichotomy. We can look at others as observers, but it is impossible to look at ourselves from any perspective other than our own. We do not experience our blood flow, but we do experience living. Viewed from the inside we appear different than from the outside. Insurance cannot pay for subjective. Subjective is whatever it says it is. However, subjective is where we make changes in ourselves. Treatment is not some mantra you chant to yourself when anxiety rises. It

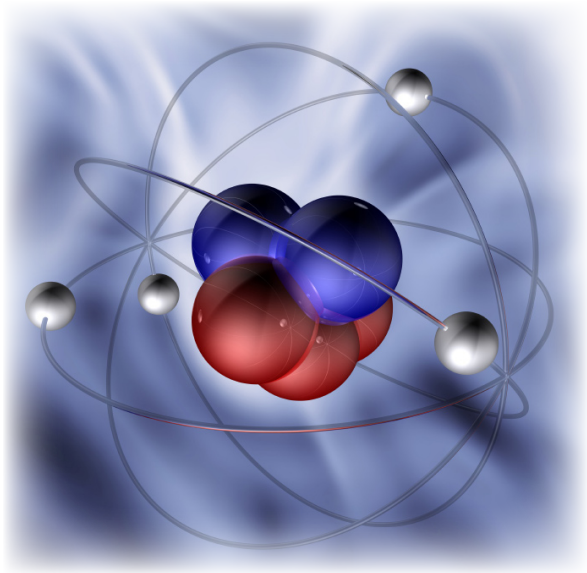
is an experience you undergo that allows you to better adapt in future situations. That experience is lived, not recited. Hence treatment is not akin to learning the Pythagorean theorem. It is more like walking point.

The problem with evidence based psychiatry/psychology is that there are too many variables. Also, the ease of measurement is inversely proportional to the importance of what is being measured. How does one quantify change in self esteem, hope, or personal integrity? My point here is that we should not throw away subjective experience and reason. Intuition, art, integrity, trust, relationship, and agency are all difficult to quantify, but critical to experience. I am concerned that Yalom is stressing the scientific method here to avoid losing the evidence-based crowd. Who will read this book if he does not speak the language of the majority of the training centers? He did not have that problem with the previous editions. This conflict will not disappear simply by acknowledging its presence. He does acknowledge that the fifth edition was a more difficult revision than earlier ones. We shall see how he handles it.

Evidence based data does not create. It confirms. It confirms what creativity produces, which happens at some inchoate level where mind and body meet. Creative lives at that junction, belonging to neither but listening to both. Without creativity, evidence based data has nothing to verify. Without verification, creativity has no evidence to present its case. But let us not forget that without intuition, empirical observation has no work to do. Empiricism always seeks its evidence under the aegis of a hypothesis. That hypothesis is not discovered in an experiment; it is the reason for the experiment.

A grotesque example of the consequences of trying to pattern mental health after physical science is the GAF score. Physicists quantify. They can tell us that an electron is 0.1 cm in length with twenty three zeros after the decimal point. Certainly that is amazing. They can even show you a picture of an atom. But how does someone quantify personal effectiveness? The GAF score rates personal efficiency on a scale of one to one-hundred. We might as well make it one to one-thousand and appear even more scientific. However, we cannot manage a scale of one to one hundred. What is the difference between a GAF of sixty-two and sixty-three? No one can say. It remains a subjective scale no matter how finely we construct it. Teachers are sometimes required to rank their students into upper, middle, and lower thirds of the class. Does anyone really think they could subdivide each of those groups into thirty-three more sections?

So let's recognize that empirical data provides critical evidence for a deterministic field with strict laws, such as physics. But when billiard balls have minds of their own, and preferences for which pocket they wish to fall into, then data becomes very complex. Quantum mechanics offers a better model for study of the human mind than Newtonian physics. One can never predict what a particle is going to do in quantum mechanics. One can only predict the probability of what it might do, although it can predict that probability with great accuracy. We may have to accept a high level of indeterminacy when it comes to human behavior. No one has ever seen a quark. No one will likely ever see a quark. We infer quarks; we do not observe them. Inference is intuitive and deductive. Perhaps behavior is like quarks. If such is the case, we will have to live with it. Observation is nice, but it is not the only way to envision a quark, or in this case, perhaps a quirk. Fortunately there are other ways to work with quarks (and behavior).



Yalom states that process is the cornerstone of group. It has been the cornerstone of the groups we ran at the VA hospital. That should not be surprising, since much of what we learned came from Yalom. He makes a clear concise statement on the state of the art:

“This point needs emphasis: It has great relevance for the future of clinical practice. The advent of managed care will ultimately result in increased use of therapy groups. But, in their quest for efficiency brevity, and accountability, managed-care decision makers may make the mistake of decreeing that some distinct orientations (brief, cognitive-behavioral, symptom-focused) are more desirable because their approach encompasses a series of steps consistent with other efficient medical approaches; the setting of explicit, limited goals; the measuring of goal attainment at regular, frequent intervals; a highly specific treatment plan; and a replicable, uniform, manual-driven, highly structured therapy with a precise protocol for each session. But do not mistake the appearance of efficiency for true effectiveness.”

Those treatment plans became the bane of my group experience, and I have a gut reaction just reading about them. We were required to write treatment plans as though they would be useful. I have never subsequently looked at a treatment plan. I do not know anyone who has. We wrote these things because an insurance bureaucrat mandated it. It had nothing to do with the experience of therapy, at least the type we practiced. In fact it interfered with treatment. For one thing, change is slow and checking it every week fosters impatience. Also, as in quantum mechanics, the observer becomes part of the system. If we are busy making objective observations we are thus prevented from empathizing. That changes the therapy. Everything ends up cognitive. So I had to write what was mandated from some insurance or medical bureaucrat who likely knew nothing about therapy, while I have run more than four thousand groups. Filling out charts was more onerous than running the groups. Any mandated standardized form



is filled out and ignored. We scan the charts for notes written by human beings. It is the lack of clinical relevance that makes notes tedious, and the Emperor's forms have no meaning.

Thirty years of group never became tiring. Then again, no one was looking over my shoulder—until recently. Lately, brief, cognitive-behavioral, symptom-focused approaches have been vying for space. But newer is not always better. Sometimes it is just newer, especially in human relations. And if everything gets reduced to a manual, people will be leaving the field. That probably would not be cost effective.