EXCITATORY GROUP PSYCHOTHERAPY.

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BECAUSE of the widespread incidence of neurosis and the comparative lack of psychiatrists, much thought and activity is being directed into the treatment of a number of patients simultaneously. Apart from economy in time, group therapy has virtues of its own and would have a place in treatment even if there were a sufficiency of trained psychiatric staff.

In addition to individual interviews, a variety of group therapy techniques are practised at the Industrial Neurosis Unit of Belmont Hospital (Jones *et al.*, 1952). The sizes of the groups vary from six patients to one hundred patients, i.e., the entire community, and the techniques correspond roughly to the classification of Rickman (1950). In the period covering 1947 to 1950 the purpose of most of the techniques dealing with the community of one hundred patients was to aid the repressing forces. By explanation, reassurance and entertainment, anxiety was allayed and support given to the failing ego. Here follow descriptions of four sessions which are typical of sessions that had been conducted during that period, and in which the object was not to diminish tension but indeed to excite tension in the group of one hundred patients.

The hundred patients and some nurses collect in the Lecture Room at 9 a.m. Each member of the group brings his own chair with him. The room is actually just too small for the comfortable disposal of the chairs, which are arranged as in a theatre. There is an aisle down the middle of the room, running from the door at the back of the room to a space or "stage" at the front of the room. Because of the smallness of the room the chairs are of necessity very close to one another, and hence there is a most intimate physical contact between the individuals composing the group. The room is barely decorated and badly ventilated. The doctor, on his arrival, has to walk down the aisle between the seated patients, who are usually chatting, smoking or reading the morning paper. With the arrival of the doctor the hubbub usually dies down, sometimes being replaced by mingled booing and cheering. Tensions are already being manifested, and in the instances where the doctor is late, additional resentment is felt and expressed by the group.

Ostensibly the subject-matter is never prepared by the doctor, and this apparently casual approach in itself arouses hostility in the group. The session is usually opened by the doctor with the words, "What shall we talk about this morning?" and this stereotyped remark is very often greeted by laughter. More often than not the doctor initiates discussions on those subjects the patients want to avoid.

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The Sessions.

(1) At one session, in answer to the usual opening question, a member of the audience replied, "Let's talk about football." This was followed by much verbal support from the group. I asked, "Why do you want to talk about football?". I was informed, "We're fed up hearing about neurosis. We get neurosis for breakfast, dinner, tea and supper. We want something else." This was followed by a burst of cheering and clapping from the group. "All right," I said, "We'll talk about neurosis." This was greeted with silence. I went on to tell the group that I knew they found it uncomfortable to discuss neurosis, but the doctors were not here primarily to please the patients. It would be quite simple to please them at these sessions. I could play them gramophone records or tell them funny stories, or give them prepared talks on travel. We could even arrange for professional entertainers to come down in the mornings. But that was not the function of the doctor at these sessions. He was not going to help the patient to ignore his illness. Rather it was his task to make the patient accept the fact that he was mentally ill, and to face the problems that had precipitated his illness. The doctor was here to improve the health of the patient. That was the prime consideration, and if in the process of obtaining this end the patient was made uncomfortable, then he must accept this as he would unpleasant medicine. Neurosis was a result of failure to recognize and tackle problems which beset us. It was the task of the doctor to help eludicate the problem, and thus give the patient an opportunity to tackle his difficulties. The first line of defence of patients was often to assume that their illness had a physical basis. It was much more flattering to their pride that their illness should have a physical basis, rather than be the result of conflicts they had been unable to face and tackle. After opening I passed the discussion over to the group. There was practically no response.

(2) On another occasion the subject suggested was "necking." This was greeted by a burst of laughter. (Now on a previous occasion the discipline of the Unit had been criticized by the staff, with special reference to the behaviour of the male and the female patients towards one another.) I went on to ask why people had laughed at the proposed subject. There was no reply. I suggested that the group were really embarrassed by the subject, and their laughter was an attempt to relieve the tension stimulated by the subject. This was followed by denials and by the statement that there was nothing immoral about necking—that sex was clean and so on. I followed up with the decision that I was going to give a talk on menstruation to the mixed group. There was silence. Up sprang a patient who very heatedly expressed the view that this was not the place to talk about such things. I asked him to continue and enlarge his point of view. He maintained that it was the duty of a mother to impart such information to her daughter, and anyway, this was an adult audience who presumably knew all about it. I expressed my doubts about the probability of the group having accurate information about menstruation, and invited him to come to the front and pretend to instruct his young daughter about menstruation. This he refused

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to do and he vehemently stated that if I continued to talk about this subject then he was going to leave the room. So I began my lecture on menstruation. He stood up, grasped his chair and began to make his way out of the crowded group, causing a good deal of disturbance in so doing. He was followed by two or three other members of the group. I immediately ceased talking about menstruation and switched to discuss the possible reasons for their withdrawal from the group. I pointed out that the sex drive was a most important factor in our instinctual make-up. That the sex urge is strong, always wanting to express itself, but neurosis, a result of psycho-sexual immaturity and its reflection in our society, namely social prejudice, made full and healthy expression difficult. Society had created all sorts of taboos about sex, and neurotics had numerous fears and feelings of guilt in relation to sex matters. I pointed out that the sex functions were often disturbed when individuals became mentally ill. I suggested that talking about sex stimulated the sex instincts, and people immature in their psycho-sexual stature developed tensions because they were unable to provide healthy satisfaction of the sex instinct thus aroused. The discussion was then thrown open to the group. There was practically no contribution forthcoming.

(3) One morning the answer to the usual opening question was a complaint. (A number of personal articles had been missed from the wards over the past few weeks. On the previous day a Mr. W— had been observed to remove a pair of socks from a bed and to march over to his own bed and place them in his suitcase. Protestations were made to the nursing staff, who on searching, Mr. W—'s suitcase, found a number of the missing articles. The men in the ward became extremely angry and threatening, and in fact Mr. W— was assaulted by one of the patients.) At this session the patients wanted to know why Mr. W— was allowed to remain in hospital after he had been apprehended. Now Mr. W— was a single man aged forty-two. He had been diagnosed as a schizophrenic in 1926, and had spent some ten years in mental hospitals between the years 1926 and 1948. A prefrontal leucotomy had been performed on him in 1947, and he was admitted here in 1948 after being out of a mental hospital for nine months. He was very irresponsible, and needed constant supervision in order to keep him to the hospital routine. He was without affect and was completely outside the group. He had no friends in the ward and wandered about the grounds alone. He did not attend the workshops, was late for his meals, did not attempt his ward fatigues, was never at the socials and invariably failed to keep his appointments with the doctors, P.S.W.'s, D.R.O.'s, etc. This morning as usual the detached Mr. W— was absent from the large group and I therefore decided to discuss his problem with the group. The line of discussion developed as follows: Aggression and hate were emotions which, if indeed not inborn, were present at a very early stage of our development. We loved and hated the same people at different times, e.g., our parents. We repressed our hate for our parents because it was " bad " to hate and also because our hate might result in reprisals. However, there was a strong need to express this aggressive urge. We could all be much more pleasant to our loved ones if we could work off our hate on somebody or something else—e.g., a subordinate or a

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political or national enemy. If the release of aggression was sanctioned by the conscience there would be no subsequent guilt—e.g., when aggression was expressed against transgressors of our moral code, or against the "bad" nations in times of war. Very often in the former case the amount of hostility directed at the transgressors was out of all proportion to the misdeed committed, and was a reflection of our defences against anti-social impulses which we all harboured. At all times we were searching for a whipping boy in order to vent our aggression "legitimately." Were not Mr. W— in hospital, then sooner or later the group would have found another object for their hostility. In all groups, national, political and religious, persecution in one form or another took place. The presence of a focus for hate facilitated the expression of goodwill and comradeship amongst the haters who had directed their hostility outside the group. I ended my contribution by pointing out that this man was ill. His anti-social behaviour was in this case a symptom. He had undergone a serious brain operation which made him less observant of our standards than the average person. He was here for treatment, which would consist of an attempt to re-socialize him and to inculcate our standards just as one would train a child. The discussion that followed was gratifying. Much guilt was expressed. They were unaware that he was not responsible for his actions, and perhaps they should have been more friendly and not left him to wander about alone. Patients promised to supervise him, and they hoped he would not be discharged because of his misdemeanours.

(4) One morning the subject suggested was marriage. A Mr. F— opened the discussion. He was a single man aged twenty-five, and had come to this country as a refugee from Germany at the age of fourteen. He was a tactless man with a jarring voice and had little inhibition. He would interrupt and attempt to join in small discussion groups without invitation, and he would air his views very volubly at the slightest provocation. At this period he was very unpopular with the group and the group expressed its feelings about him in no uncertain fashion. Mr. F— droned on and on in his high-pitched, irritating voice. Patients became restless, began to whisper and cough and mimicked his foreign accent. After about ten minutes one of the mimes, a Mr. T—, stood up and protested very forcibly against the stupidity of Mr. F—, who was a single man and therefore could know nothing about marriage. Mr. T—, an aggressive psychopath, aged forty-nine, was married to an epileptic who was certified and had been in a mental hospital for sixteen years. For the past fourteen years he had been living with another woman, who had adopted his name, and there was a twelve-year-old son resulting from this union. "Mrs." T— had informed me that Mr. T— was an ego-centric, irritable and aggressive man, who was very cruel to his son. She had urged Mr. T— to get a divorce from his wife and marry her, but he had seen no reason to take this step. His egocentricity and his aggression had driven her to direct more and more attention and affection to her son. She was very dissatisfied with the present domestic state, and was determined that when he left hospital their relationship would cease. At individual interviews Mr. T— confirmed most of his "wife's" utterances in one way or another, but would never admit to a sadistic attitude towards his son. Mr. T— con-

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tinued to taunt and mimic Mr. F— unmercifully. I intervened and suggested that Mr. T— was attacking Mr. F— for reasons other than that he was ignorant of marriage. Mr. T— denied this, and was most indignant at the suggestion that he was being at all hostile. I informed the group that I knew of Mr. F—'s unpopularity and suggested that we discuss this unpleasant situation. Showers of reasons for his unpopularity were poured forth. He was arrogant, he was voluble, he was tactless, and so on. I suggested that although these reasons were perhaps valid, there might be other mechanisms at work. I then went on to discuss aggression and hate on the lines of the session described above. I continued, to point out that Mr. F— was a foreigner who spoke with an accent. He was different from the rest of the group. He was strange—a danger. The group always united against strangers to combat them more effectively. Were not Mr. F— a German, then his shortcomings would not have been *so* disturbing to the group. He might have been unpopular, but not so unpopular as he was in fact now. I informed the group of what little I knew about Mr. F—'s background. He had felt rejected by his parents and he had obviously been rejected by his father country. He had always felt unwanted, and he was apparently not very welcome in our group. True he was not a personality who was easily acceptable—he seemed to be deliberately provoking hostility as if he had a need to recreate this pattern of rejection. Perhaps his arrogance, his volubility, his tactlessness were a result of frantic efforts to obtain acceptance by society, but his unconscious need to be rejected was stronger than his conscious desire to be accepted. I concluded that we should always question our motives in any actions which might cause even the slightest unhappiness to others. There was unhappiness in the world enough without thoughtless and unnecessary contributions. It is understood that we all lose our tempers and are cruel at one time or another, but on these occasions we must recognize and accept the fact that in most cases we are looking for an opportunity to vent our aggression. When I had finished there was complete silence. There was no verbal contribution from the group and I walked out through the silent group. As I left the room the unusually long silence was broken by prolonged and vigorous clapping of greater intensity than that usually accompanying the end of a session.

I made my way to my clinic, and had not been there five minutes when there was a knock on the door and in walked Mr. T—. He was obviously disturbed and near to tears. He hoped that I had not really thought that he had been deliberately cruel to Mr. F—. He had not meant to be malicious with his taunts, and he had not realized that he was making anybody unhappy. Spontaneously he suggested that perhaps he had been unwittingly cruel to his own son in this fashion. I reassured him that I was certain that he was not being deliberately cruel to either Mr. F— or his son, and I suggested that in future his attempts at humour might have less venom now that he realized the possible effects his behaviour might have on others. Some days later I was stopped by Mr. F—, who thanked me for bringing this problem to open discussion. He had noticed a marked change in the attitude of the group towards him. *They* were more friendly and tolerant and seemed to be accepting him more readily. On questioning a number of patients, including

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Mr. T—, a week after this session they confirmed Mr. F—'s observation that he was being absorbed into the group, but they maintained that this was because Mr. F— had changed. He was not so rude, tactless or voluble as formerly. It was not *they* who had changed; *they* maintained that *they* had never really disliked him in the first instance.

For the rest of his stay in hospital Mr. F— became more and more incorporated into the group, though it could not be said that he was ever very popular. It would be a fair comment to say that the group had accepted his shortcomings and made some allowance for them. It is interesting to know that nine months after his discharge from hospital Mr. T— was very well. He was working as a navvy, although there was no financial necessity for him to work at all. His "wife" informed me that she was most satisfied with the behaviour of her "husband" in general and towards her son in particular.*

Discussion.

The induction of tension is commonly employed in individual psychotherapy of all kinds. This induction may be assisted and enhanced by barbiturates, inhalations of ether or carbon dioxide, or may take place on the analytical couch. The end to which this induction of anxiety is directed varies with the depth of therapy practised. For example, a fear-provoking situation which is conscious or pre-conscious may become more tolerable by the process of repetition in the treatment situation—this is an attempt to strengthen the ego and its defences. The therapist may provoke a tension state by attempting to recover repressed material, which approach involves a limited assault on the ego defences. Finally, on the analytical couch, anxiety is aroused by overcoming resistances and presenting tension-producing interpretations—this involves a wider attack on the ego defences with, in addition, the development of an awareness of those defence mechanisms, leading to a greater redistribution of the mental forces than that achieved by more superficial approaches. In simple terms, the aim of all anxiety-provoking therapy is to mobilize this emotion, to liberate it and to direct it into socially useful channels, when the individual finds increased security through better control.

As mentioned in the introduction, the object of excitatory group psychotherapy is the deliberate excitation of tension in the community of 100 patients. While other community techniques practised here were directed towards the end of allaying anxiety, e.g., by instruction in elementary anatomy and physiology, by discussion of subjects related to difficulties in employment and in the home, excitatory group psychotherapy was essentially an assault on the defences of the patients with the hope of a gain of some insight as the end in view.

There is no doubt that a considerable degree of tension was provoked at these sessions. The silences obtaining in the first two sessions described and the reactions in the latter two sessions were quite remarkable when compared with the immediate effects of other types of community techniques practised at that time. After excitatory group psychotherapy, other workers on the

* Mr. T— has relapsed since this article was written.

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unit (doctors, psychiatric social workers, disablement resettlement officers, work therapy instructors) who themselves had not attended the session would spontaneously report back the repercussions thrown up by the session. The tensions aroused in the groups were dealt with in two ways. When silence resulted as in the first two sessions described, the tension was released after the dispersal of the large group, e.g., the subject-matters were discussed in small groups of six to eight patients led by a doctor or psychologist, or in spontaneous groups at work therapy and at individual interviews with the doctor, psychologist, psychiatric social worker, or disablement resettlement officer. In the sessions typified by the latter two meetings described, when "here and now" problems were raised, an attempt was made to deal with the tensions immediately and to attempt to canalize them to effect a change in group attitude. In the latter two sessions an undoubted change in group attitude was achieved, but one can merely speculate as to the persistence of such changes. For example, Mr. W— was readmitted to mental hospital a few days after the third session because he was considered to be too ill to ever cope with life outside a very sheltered environment. However, Mr. F— was not discharged until some months after the fourth session, and during those months there was a gradual improvement in the group attitude towards him.

What changes occurred to patients at an individual level is difficult to assess, although in the cases of Mr. T— and Mr. F— more or less dramatic changes in attitude were achieved. However, some points can be made when an attempt is made to understand the reactions from the point of view of group phenomena.

The doctor adopts a leader role in the group situation. He is helped to achieve this by the cultural concept of the doctor as a teacher and healer. He occupies a position of faith and trust in the mental constellation of the patient. The doctor centres attention on himself by standing alone in front of the group when he speaks. He is just like a parent or teacher making demands or delivering rewards. The adoption of suggestions from such figures is a well-learned habit. Ezriel (1950), discussing small analytical groups, points out that a common group tension develops when the subject-matter bears some relevance to the unconscious fantasy dominant in the minds of the group constituents. Thus while the doctor in a small group may be able to take a passive role and wait until a significant subject-matter is precipitated, the doctor dealing with a large group must take an active role. He must choose a subject which he knows will have significance to patients in general, i.e., he must serve as the common denominator of the community tension.

The doctor is an attacking doctor. He does not prepare his talk as Dr. X does, and resentment is frequently expressed by the patients when they ask, "Why is there no pre-arranged topic? Why do you always ask, 'What shall we talk about?'." To add insult to injury, the doctor frequently rejects the suggestions proffered in reply to the opening question of "What shall we talk about?." The nature of the topic eventually chosen by the doctor is again an indication of his threatening character, for the topic is

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always something which the doctor feels has much emotional significance to the larger part of the patient community (and, of course, to himself).

The patients constituting the group are crowded together and are seated as children in the school-room, i.e., in a receptive position. In addition they are disposed as an audience in the theatre, i.e., in a dramatic situation—a situation which is associated with free emotional participation. Moreover the application of an excitatory stimulus to a group, mentally set for a common stimulus, produces a greater emotional response in the individuals composing the group than the feeling aroused in an isolated individual exposed to the same stimulus, the common stimulus here being the subject ultimately chosen for discussion, and which the doctor feels has emotional significance for most of the individuals composing the community.

In a previous paper (Merry, 1953) I discussed the relative roles of individual and group psychotherapy, when both types of therapy are practised on the same patient. There I pointed out that the type of doctor-patient relationship created at individual interview played an important part in the degree of participation of that patient in the various group therapies practised in the Industrial Neurosis Unit. A good doctor-patient relationship was most useful in helping the patient to derive maximum benefit from the group situations. An attack such as was carried out on the one hundred patients as a community would, if directed at the patient at an individual interview, tend to destroy the good relationship so essential between the doctor and patient where superficial types of psychotherapy are employed. The attack directed on to the group leads to a more ready acceptance of unpalatable suggestions. Since the attack is not directed at a particular individual, the recipients of the material are as it were anonymous and may be able to accept suggestions without signifying their acceptance, i.e., there is less guilt brought to the surface.

The group situations described bear a resemblance to those obtaining at the meetings of various religious or political sects. There, a crowded group in an emotionally charged setting results in changes of attitude in some members of the group due to the acceptance of new beliefs in the period of increased suggestibility that immediately follows a rise of emotional excitement (Sargant, 1949 and 1951).

It is suggested that this technique used so widely in religious and political fields should be exploited in psychotherapy, the object being to attempt to impart insight with the minimum of damage to the doctor-patient relationship at an individual level.

References.

Ezriel, H., *J. Ment. Sci.*, 1950, **96** : 774.
Jones, M., *et al.*, *Social Psychiatry*, 1952. Tavistock Publications.
Merry, J., *J. Ment. Sci.*, 1953, 99, 301.
Rickman, J., *ibid.*, 1950, **96** : 770.
Sargant, W., *Proc. Roy. Soc. Med.*, 1949, **43** : 1007.
Idem, *Brit. Med. J.*, 1951, ii : 311.

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