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'Differences in the Didactic Matrix'

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'Understandings, Misunderstandings and Illusions in the Research Matrix'

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'Bernardo: Who's there?
Francisco: Nay, answer me: stand, and unfold yourself.'

Hamlet, Shakespeare

Dear Colleagues and Friends. Dear audience.

Since the start of empirical psychotherapy research one hundred years ago, psychotherapy has now become an evidence-based first choice in the treatment of a range of mental disorders. In anxiety disorders and depression, more lasting effects have been found of psychotherapy than of medical treatment (Hougaard, 2021)

In 2018, group psychotherapy was recognized by the American Psychological Association (APA) as a specialty, which are 'defined areas of psychological practice which requires advanced knowledge and skills, acquired through an organized sequence of education and training.' This decision was based on evaluation of the empirical, theoretical, and clinical literature on group treatments (Rosendahl, 2021).

Rosendahl and her diligent team published in 2021 a review of group psychotherapy research published within the past 30 years, predominantly focusing on outcomes of group treatments for patients with various mental disorders. Results strongly support the use of group therapy and demonstrate outcomes equivalent to those of individual psychotherapy. The research also appears to emphasize the effect of feedback on outcomes in group treatments and an association between treatment outcomes and group cohesion and alliance (Rosendahl, 2021)

All is well then, or is it? Most studies in these reviews are about CBT. The psychodynamic and psychoanalytic branch is sparsely represented.

However, some research has been done in group analytic psychotherapy since I gave a lecture here seventeen years ago titled 'Research in the Didactic Matric' (Valbak, 2005) and with the motto 'Research in Training and Training in Research'.

A good summary was the systematic review of group dynamic and group analytic psychotherapy research from 2009 (Blackmore et al., 2009)

A newly published study by Ole Østergård and coworkers from Denmark investigated the treatment effects of focused short-term group analytic psychotherapy of 66 students referred to a student's counselling center. The study found large pre-post effect sizes. Moreover, it was examined whether outcomes were predicted by the client's psychological mindedness and personality structure as measured by the Operationalized Psychodynamic Diagnosis (OPD). The study showed, that these measures could be helpful, when selecting clients for short-term group analytic psychotherapy (Østergård et al., 2022).

But overall, quantitative research has been infrequent, and the value of it has always been the subject of stuck opinions, like a split in the society.

- Before I go to the critic of the quantitative research, I will talk about the contexts for the practicing of the group analytic psychotherapy.

The unhealthy development in the Mental Health Service

In the Mental Health Services in Denmark, the more disturbed patients get access to the hospitals and to the specialists there. Minor illnesses are to be treated by private practitioners, psychiatrists and psychologists, however still paid by the health systems in the five regions, who have responsibility for all health services.

Patients are on the basis of 'evidence' and the national recommendations, allocated to treatment packages with a predefined focus and timeline for the sessions. The offered treatment, with few exceptions, are determined by the diagnoses of the patients, which entails that initially, they must be assessed. Twenty years ago, the government decided to give their citizens a guaranty to be examined within thirty days. Accordingly, locally, resources were moved from treatment to assessment. Relief until the government then offered a treatment guarantee. With the same economic coverage, that led to shortening of treatments and heightening of the thresholds to get help. Especially the long-term and complicated patients in the psychiatric system were let down with this scarcity of resources.

Already in 1997, Wayne Fenton wrote:

> 'Available research on the psychotherapy of schizophrenia has done little to slow a mean-spirited and profit-driven erosion of compassionate care for psychiatry's most vulnerable patients.'
> (Fenton, 1997).

In this same period of time, the management required the staff to document still more of their procedures, regarding medication, violence, coercion, exercise etc. Discharge became guided

by patients' improvement on scales like General Assessment of Functioning (GAF) and Hamilton's Depression scale.

The technology fetish

There is still another obstacle to a 'intelligently kind and caring' (Ballatt & Campling, 2011) psychiatric health system, which is the overwhelming belief in the Information Technology systems.

In the iconic film from 1968 'A Space Odyssey 2001', the main computer H.A.L. 9000, which has human features, is trying to take over the spaceship by ignoring the commands given by the crew. It is dismantled in the last moment. Taking one step further in the alphabet, its name 'HAL' reads 'IBM'. Stanley Kubrick gave the prophecy that one day the big companies would control our IT systems and dominate our lives. Ring a bell? It's a fact, that digital technology plays an increasingly large role in our daily work, mostly by engaging the clinicians in documenting, reporting, controlling and directing their interaction with the patients.

Also, in assessment and treatment we are occupied with technical 'solutions'. In the research unit in Aarhus, some research is about 'machine learning' and 'virtual reality' in the treatment of phobia and schizophrenic illness.

When I was employed at the neurosis clinic in 1988, the invitation letter to the patients was made personally and signed by the therapist. Now it's computer text with computer letters and computer design, and all communication goes by the secretary, who exclusively books the room and receives apologies and other messages from the patients. The therapists have no personal secretary assigned. Only sanctioned and secured communication routes are allowed between the therapist and the patients according to the 'general data protection regulation' (GDPR). To ensure the patient's privacy, the therapist cannot without special permission contact the patient by phone, email or text message. This is of course cumbersome.

Thus, we must overcome several threats towards basic rules of analytic psychotherapy, like unity of time and place, 'holding' principles, security and confidentiality, when we have decided to practice group analytic psychotherapy in the Mental Health Service. I am concerned about this negative influence of the psychical context on psychotherapy, which I think mirror the neglect of psychodynamic thinking.

What I see - in this time with unmanageable tasks - is a more or less unconscious fantasy, that technology will solve our problems. That's an illusion – in psychotherapy as well as with the climate change challenge.

The obstacles that come from the technologization of the management are much more influential on the possibilities of having group analytic therapy, than the challenge of having research involved.

Why research?

What motivation could we have for doing empirical research?

First and foremost, we have an ethical obligation to minimize the number of patients that are unchanged or have harmful experiences from the group. - And there are requirements for documentation of the value of our method, from the management and the resource givers. - For some clinicians in private practice, outcome research could help get their profession approved and certified. - Also, to be mentioned, from time to other efforts have been made to include (more) research as part of the training in Group Analysis.

Regarding harmful experiences, although not strictly about groups, I must mention Tom Main and his famous article 'The Ailment' (Main, 1957) about a sado-masochistic dynamic in the treatment of patients at the Cassel Hospital in London. He wrote about the need to scrutinize the treatment in the hospital, the process of establishing a research attitude, the interpretation of the results and what it meant to the clinical work.

In the 60's Irwin Yalom (Yalom, 1971) studied the encounter groups and found negative outcomes from these groups.

In the 80's, Sigmund Karterud and coworkers (Karterud, 1985) did several studies on inpatient groups at the therapeutic communities and psychiatric wards in Norway. Their studies indicated - for psychotic patients in short- and intermediate term wards – that confronting group therapy is detrimental and that community groups may become anti-therapeutic pseudo-groups. Another unpleasant finding was, that the youngest and most inexperienced staff was put in charge of the most difficult groups.

Karterud gave the Foulkes Lecture in 2011, where he - on the basis of a large amount of data - doubted group analytic psychotherapy as a reliable method and treatment for borderline patients. He had experienced that the group did not have enough structure and support for this vulnerable, emotional unstable patient group, and suggested instead Mentalization Based Treatment (MBT). He spoke

> 'Most clinicians intuitively moderate their technique with such groups, becoming more active, more supportive and more attuned to the individual. The therapist thus takes a more active role on behalf of the group, in order to consolidate and maintain the group, and provide meaning to what is going on.'
>
> Karterud, 2011

We know about 'anti-group' phenomena and scapegoating in group analytic psychotherapy, but do we consider drop-outs or suicidal acts as caused or initiated by our groups? Do we register scapegoating, re-traumatization and drop-out as a negative outcome? Are we

appeasing ourselves by thinking, that patients expectedly will feel pain and agony as they involve themselves in the treatment?

Clearly, we must always consider which patients would probably benefit in our groups and realize, that not all patients are fit for group analytic psychotherapy let alone group analysis.

Is group analytic psychotherapy an evidence-based practice?

The effectiveness requirements were strongly forced by the introduction of New Public Management in the late 80'es with its strong focus on financial control, value for money and increasing efficiency.

A milestone for empirically supported treatments was the American Psychologists Associations task force 12: What works for whom'. A hierarchy was built, in which evidence was ranked, and it was recommended that a complete list of documented efficacious treatments be established and up-dated, as new evidence was provided.

Unfortunately for the psychoanalytic therapy, the cognitive-behavioral therapy could present a much larger number of studies proving effect, that the rather sparce number of studies about psychodynamic treatment. Therefore, the recommendations in the national health service programs were loaded with CBT.

The APA definition of evidence-based practice was:

> 'With the best available and (clinically) relevant research to
>
> 1. Formulate a problem or a question,
> 2. Examine the available scientific evidence to answer the question,
> 3. Make a critical assessment of whether this is relevant, and
> 4. Integrate the response with your own clinical assessment and experience'.
>
> APA, 2005

Unfortunately, the last two steps in this guidance were often forgotten, when making national recommendation for treatment of the different psychiatric diagnoses.

The language of research: Validity, reliability and some biases

Let's turn to the challenges in making empirical research. The base of methodology is to make the study valid and avoiding presumptions and prejudgments. Biases are beliefs that are not founded by known facts about someone or about a particular group of individuals. Bias covers

the researchers' unconscious presumptions, wishes and prejudgments in the research process. Here are a few examples:

'The Rosenthal effect is the situation in which an investigator's expectations about the outcome of a given study unwittingly affect the actual study outcome. A researcher may use blinds to prevent the Rosenthal effect from occurring and biasing study results. Patients often reward the researchers or the therapists by answering what they want to hear. We talk about researcher sympathies or 'allegiance', when we unconsciously have sympathy with our own method.

The Hawthorne effect is a type of reactivity where individuals modify an aspect of their behavior in response to their awareness of being observed. Productivity in a factory in Hawthorne was temporarily better by any experimental change in environment.

> Here is an example form the medical world:
>
> A vitamin pill was supposed to give elderly home-stranded people a better life quality, mood and energy. The pill was for reliability reasons given every day by a visiting medical student. Thus, the relationship became a confounder to what caused the recovery.

Publication bias occurs when the outcome of an experiment or research study, biases the decision to publish or otherwise distribute it. Publishing only results that show a significant finding, disturbs the balance of findings in favor of positive results. Despite similar quality of execution and design, papers with statistically significant results are three times more likely to be published than those with null results. This unduly motivates researchers to manipulate their practices to ensure statistically significant results, such as by data fishing.

(*https://en.wikipedia.org*, 2022)

Corruption of science takes many forms and cannot be totally eliminated. Scientific dishonesty is among the more serios offences. That's when a person on purpose takes some illegal and immoral steps, for example invents fake data. We have University committees to investigate such cases.

In the medical world the young researcher will soon discover that 'the money comes with the task', or should I say 'the task comes with the money'. Especially private money from 'big pharma' companies do influence what will be investigated.

Scientific journals have their specific policy to what kind of papers they will welcome and accept. And all these choices have unconscious elements. In my twelve years in the editorial committee of the International Journal of Group Analysis, I found that despite the declared intention that all papers would be welcomed, the interest in databased articles was moderate and the procedures with this kind of papers were not fostered or cared for.

We are always personally involved in the process of research; we cannot be neutral. What shall be the focus for our research is a political choice, so is the design and the research method.

The funding of research is political and sometimes determined by other interests than the patients. Public funding providers are politicians, and they are always looking for quick solutions and low-cost interventions, for example help delivered by semiprofessionals or relatives replacing professional expertise.

What is Science

During my time in the Management Committee of the Group Analytic Society (GASi), I met a reluctance to call meetings scientific. Apparently, the term has been associated or equalized with positivistic research.

Adele Mittwoch was a prominent lady in the society. In her Foulkes lecture in 2001 with the title 'Our Place in the world of Science: What is at stake?' she scorns the observant researcher, who cannot see the important moments in therapy. What happens in the group session - she proclaimed - cannot be intercepted by measures! She expressed also the deepest aversion for questionnaires and for the word 'science'. She preferred the German word 'Wissenschaft'.

However, the word 'science' originally comes from the Latin word 'scientia' which means 'knowledge', 'a knowing or experience'. By the late 14th century, 'science' meant in English: 'collective knowledge'. It has consistently carried the meaning of being a socially embedded activity: people seeking, systematizing and sharing knowledge.
I do think, we have a scientific society. It is also true, that most databased research with quantitative methods has been done by medical doctors affiliated to universities or to hospitals. Some researchers even have the research as their primary work.

It is well known that there is a language gap between the researchers and the clinicians. There are concepts to understand, a 'research language'. There is also a knowledge gap on how to navigate in designs, methodology, measures, statistical analyses and data presentation.

Researchers on the other hand must listen to the clinicians. What clinicians want most from research has been surveyed? Most desired is an answer to the question 'what makes the change in psychotherapy' (Ogrodniczuk, 2010; Tasca, 2015). That is yet to be delivered!

Large scale research with larger populations and randomized controlled designs requires funding - for many years. Most clinicians will not have access to those fundings, which can be the basic for envy and rivalry.

The ambivalence to quantitative Research

For some years a college of ours, dr. and psychologist Susanne Vosmer has written a column in Contexts, the group analytic magazine for the society's members.

The head line is: 'A column dedicated to demystifying psychotherapy research - love it, hate it, or both … at least try to know what it's all about!'
In the Contexts December 2021 she writes this about a meeting:

> 'The faces of many group analysts were as grim as the title of the research conference: '*Can group psychotherapy survive NICE?* [The National Institute for Health and Care Excellence] *Examining the evidence'.*
>
> The atmosphere was tense. There were traces of trauma and despair in the air. Some analysts vehemently questioned whether group analysis had to become "quantitative", others grasped that research knowledge and research evidence were important. It was survival analysis in action, both in a statistical and analytical sense.'
> Susanne Vosmer, 2021

No doubt Vosmer has a dramatic pen, but she also picks up this airy discomfort about quantitative research in the society.

Steinar Lorentzen has been one of two handfuls of researchers, who have persisted in doing empirical research in group analytic psychotherapy for the benefit of patients and our profession. His work so far had mainly two sources: His own practice with groups patients (Lorentzen, 2002) and a multicenter study comparing short term (20 sessions) with long-term (80 sessions) group analytic psychotherapy (Lorentzen, 2018). To perform the last study according to scientific outlines, a so-called 'manual' was written, 'to be followed' by the therapists. Later this manual in an elaborated version was published in English and as such known to and used by training institutes. 'Manual' in the English dictionary means 'a book that gives you practical instructions on how to do something or how to use something, such as a machine'.

Teaching group analytic psychotherapy by a manual did provoke some colleges, like Kevin Power, who gave a review of this book in the Journal of Group Analysis.

He wrote (Power, 2016):

> 'If group-analysis is understood - by untrained or partially trained readers - as everything in this book, then they will not be provided with a sufficiently complex picture of what it involves'
>
> '……. I feel that he [Lorentzen] misses some crucial points about group analysis as a psychodynamic psychotherapy as well as a profound way of understanding human interactions. The emphasis is on research and getting people 'better', only

> this seems to arise from a medical-model orientation and does not acknowledge the deeper links to humanity's besetting social ills…'

Then quotes Foulkes:

> '.. no-one should embark on this [conducting group-analysis] who has not the measure and control of his power firmly in his blood and system, lest he suffer the fate of the sorcerer's apprentice'. (Foulkes, TGA, p 287).

Power is indeed concerned, that the manual will be used for more than is intended, which he imagines is without the proper training, personal therapy and supervision. He also doesn't think that group analytic psychotherapy shall be restricted to the diagnoses mentioned in the title.

In the new version of his book (Lorentzen, 2021), Lorentzen points out, that the guidelines are based on research (the subtitle says 'An Integration of Clinical Experience and Research'). Is he insinuating that group analysis is not?

Quality Assurance

Maybe the anguish is not so much with the method as it is with its application and the power and control behind.

In a paper presented at the GAS 2005 Symposium in Molde in Norway and with the wonderful title: 'Chopping up the Rainbow: Quality Assurance and the Challenge to Group-Analytic Training', Jane Campbell - as a staff member - offered a personal experience with accreditation of the group analytic training at the Turvey Institute in England.

She did acknowledge quality assurance as the means, whereby a university prescribes and monitors the academic standards of the courses, it accredits. This was not in question. Campbell was uneasy about the measurements used and wanted - in her expression – to (I quote):

> '… resist the engulfing and possibly dehumanizing practice of a bureaucracy whose power is never challenged?'
>
> Campbell, 2005

She also denounced the word 'Training' - I think she associated to a redundant, military exercise - and suggested 'education', which comes from 'educere' meaning 'leading the way'.

The wrestling with these external requirements is ongoing:

> In Denmark, in the process of becoming a clinical psychologist and specialist in psychotherapy (for example 'group analyst'), you shall be educated among peers, entailing that in modules of teaching you can only be in groups with less than 25% non-academics.

> This claim is part of a long fight to upgrade and refine the psychologist title and reputation. Now the requirements have been extended also to involve the therapy groups in our education. Let alone the idea of keeping the small groups foreign, it reduces the diversity in the groups and makes the therapeutic potential smaller. Lately, it has been decided mandatory to present some cases on video for the supervisor, who shall certify that the candidate preforms sufficiently well!

More critic of the quantitative research

Farhad Dalal, - author and in private practice as group analyst - has written an interesting book called 'CBT: The Cognitive Behavioral Tsunami. Managerialism, Politics and the Corruption of Science' (Dalal, 2018)

He gives a critical description of how New Public Management has devastated the Mental Health Service in England. Fahad pierces the diagnostic culture, the psychologization of normal existential conditions and distances himself from the focus on production, which leaves the patients without help at all. He sees a fake, pretending culture, where the language serves to hide the huge shortcomings of the system.

In the chapter concerning science, he names 'bad science', which he describes as (I quote)

> '… sloppy, careless science, and 'corrupt science' in which intentional bad science is knowingly displayed as good science.'
>
> (Dalal, 2018)

Farhad lists nine ways to corrupt science. Most of these examples are well known biases and pitfalls in the research process. His language is indignant, ironic and sometimes scornful. And if you are on his side, its lovely.

However, the study he has chosen to criticize and generalize from is about the use of 'Mindfulness' to prevent relapse in depression. It is rightly not very well performed, and have several flaws.

Another point in his critic, he illustrates with an anecdote:

> A researcher's findings did not look very impressive after a lengthy empirical study. He talks to a statistician, who can help him manipulate data to be significant.

Here we have two immoral men, a psychologist and a statistician - for a change no doctor involved here! Are we led to believe that all studies are somehow manipulated?

No researcher or therapist can claim that the processing of what is happening, is not based on reducing and sorting the input, and thereby a (biased) choice.

Farhad is surprised that only two significant studies are needed to obtain a license for a new therapy form. I am not familiar with these regulations. But here is a counter-question: What must be acquired to get a license to do group analytic psychotherapy?

The placebo effect in psychotherapy is well known, closely connected to the prestige of the therapy or the therapist.

> In 1994, a college and I visited the day hospital unit for eating disorders at the General Hospital in Toronto. To this treatment center came young people, who had suffered for years. Just before we entered the rather common looking hospital ward and corridor, we noticed two 'golden' plates at the wall next to the entrance saying:
>
> 'This department has been awarded as the best clinic in America for the treatment of eating disorders.'

Definitely, placebo plays a positive role in all psychotherapy!

> Three years later studies showed no advantages of their program compared to other places, so the plates were removed again!

Farhad's critic of science is also known to researchers, and I think, he happens to paint all empirical research black.

I have come to understand, that we have at least two kinds of working realities: A group of trained group analysts working in the private sector. They meet more sound patients or clients or persons and understand and call their work 'group analysis'. We have mostly anecdotical reports about what they are actually doing, and if it works. Another group of trained group analysts are working in the Mental Health Service and call their work Group analytic psychotherapy. Their public financed therapies are usually based on diagnoses, focused and short-term, that is less than 2 years. These group therapists had faced challenges with their psychiatric patients and from experience learned to be more directive and supportive. In this category there are more therapists who are engaged in clinical empirical research.

To avoid any kind of evaluation when working in the public health service seems to me an infantile illusion.

Some therapists in private practice have no incentive to systematically rate the success of their practice. Fortunately, they may benefit from research made by researchers associated with universities and hospitals. Some results from outcome-research in group dynamic psychotherapy, like mentalization based therapy (MBT), might even substitute, what we lack in evidence with group analytic psychotherapy.

Can we do research in group analytic psychotherapy?

Can we do quantitative research with group analytic psychotherapy?

Professor Dorothy Whitaker takes this question seriously and gives what I still think is a sweet and straightforward advocation for research. She thinks the main question is: How do we know if our group members benefit from therapy?

One of my teachers in this field, Bengt-Åke Armelius from Umeå in Sweden, wrote a little book about psychotherapy research where he advocates, that qualitative research and quantitative research can be combined. He finds a false dichotomy in the question of what kind of research should be used (Armelius & Armelius, 1985). Personally, I have experienced, that both quantitative and qualitative methods are applicable, and can be done in a way, that have little impact on the therapeutic interaction.

> In Aarhus we gave the group patient a package of questionaries before start of therapy, two months after termination and then again one year after therapy. The therapist delivered the first package to the patient to take home. No further reference to this standard evaluation was made. The two other packages ('after therapy' and 'follow -up') were sent by the secretary by post in accordance with a written agreement with the researcher. This meant a minimal overlap between therapist and researcher.

Other much more intensive feedback mechanisms between patient and therapist have been advocated, which strengthens the alliance, but also has been criticized for the Rosenthal effect (Østergård, 2020).

In Aarhus, a psychiatric diagnosis is the key to be offered therapy. However, for many years now the group analytic treatment offer in Aarhus has been the only psychological treatment in the psychiatric service, where a specific diagnosis has not been the ticket to ride and - much more interesting - where a long-term psychoanalytic treatment has been possible!

My concern is that group analytic psychotherapy in some countries -like Denmark - misses its position as a treatment offer in the psychiatric service. This is particularly important, because group analysis is the only theory that has a credible and coherent bid for what happens not only in the individual and between individuals, but also - and primarily - in the group.

Conclusions

I have chosen these conclusions:

- Exploring is a fundamental human heritage. We are 'seeking' animals. And the group is a human laboratory.
- Empirical research has always had a place in the matrix in applying Group Analytic psychotherapy, both historically and presently.

- The value of measures must be separated from their use. We know only little about what works in therapy. In research, it is still like a 'black box'. We try to measure subjective phenomena that derive from being in a group.
- Measurements and control are not the same and wrongly equalized.
- Outcome research has value for those providing the money, and for the practitioners to argue for their usefulness. It's an illusion that we can avoid claims for quality working in the mental health service.
- Empirical quantitative research is time-consuming, takes many resources and is quite difficult to exercise. It must always discuss its methodically shortcomings and weaknesses, and only in the discussion with colleges about the research process, interpretation of results and possible clinical use, it becomes real knowledge = science.

Use and purpose of EGATIN's Research web site

Let me finally mention EGATIN's project with a research section on the website. It builds up slowly and I don't have any presumptuous ideas about it. There are other places to find databased studies about group analytic and group dynamic psychotherapy.
But for some of us – should need or curiosity emerge – the research section is: 1. A service with easy access to newer research of clinical relevance for psychodynamic group psychotherapy, 2. Material to be used in Group Analytic training, 3. An inspiration to what can be investigated and 4. A possible place for finding other colleges with research interest.

I will end my presentation expressing the pious hope, that researchers and clinicians can learn to better understand each other, clear up misunderstandings and give up illusions that hinders cooperation.

Thanks for your attention!

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