

**GROUP PSYCHOTHERAPY—A TECHNIQUE  
IN SEARCH OF A THEORY**

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## Chapter XIV

### GROUP PSYCHOTHERAPY—A TECHNIQUE IN SEARCH OF A THEORY

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*Editors' Summary:* The author contends that the most important function of group psychotherapy is "the provision of a forum for working through the pre-oedipal hunger that is at the root of most depressions and defects of the ego." He maintains that traditional forms of psychoanalysis often do not resolve a "yearning for the unreachable mother" because the relationship is not intense enough to sustain the patient through the process of mourning. Increased intensity may be achieved through a grafting of techniques such as primal scream, bioenergetic analysis, Gestalt and transactional analysis onto the basic psychoanalytic model. In Crisis Mobilization Therapy, developed by the author, the therapist, functioning analogously to a surgeon, affords patients an opportunity to reexperience emotional conflicts "at crisis points of maximum tolerable anxiety" and this attempts to activate the observing ego during the working through process. Various provocative techniques are used to overcome the ensuing resistance, which is often extreme.

#### THE CONFUSION

The existence of a wide diversity of individual and group therapies which vary radically in their underlying conceptual and technical approaches is an extraordinary development in our field, and requires an explanation. The fact that so many solutions are offered for the same set of problems clearly indicates that the truth continues to elude us. Before the elucidation of the bacterial and the viral bases of contagious illnesses, Man believed naively that supernatural forces cause most calamities, and offered tribute to non-existent deities which were believed to have been responsible for all tragedies. Dunglison's Dictionary of Medical Science [6] published in Philadelphia only one hundred years ago states, under the term *Contagion*:

"Contagious diseases are produced either by a virus called contagium... as in small-pox, cow-pox, hydro-

phobia, syphilis, etc., or by miasmata proceeding from a sick individual as in plague, typhus, measles and scarlatina... Physicians are, indeed, by no means unanimous in deciding what diseases are contagious, and what not. The contagion of plague and typhus, especially the latter, is denied by many."

Tuberculosis was non-existent then as a known medical entity, but its predecessor, Consumption or Phthisis Pulmonalis, is specifically mentioned as possibly being contagious, "but apparently without foundation."

The condition known as hysteria is also described:

"... it received the name hysteria, because it was reputed to have its seat in the uterus... but it is not confined to the female: well-marked cases are occasionally met with in men... [it consists of] alternate fits of laughing and crying, with a sensation as if a ball—Bolus Hystericus—ascends from the hypogastrium towards the stomach, chest and neck, producing a sense of strangulation. The attack appears to be dependent upon irregularity of nervous distribution in very impressible persons."

The latest of therapeutic innovations for this psychiatric condition are also given:

"... dashing cold water on the face, stimulants applied to the nose, or exhibited internally, and anti-spasmodics form the therapeutic agents. Exercise, tranquillity of mind, amusing and agreeable occupations, constitute the prophylactics."

Such certainty in the face of what we know now to have been blind ignorance should imbue us with humility as we expound present day theories. Mental illness is as old as other illnesses, yet the specialty of psychiatry as a scientific branch of medicine is relatively young, and its present state of development has often been compared to that of some of the older medical branches a hundred years ago. Even so fundamental a question as the nature of mental illness is not agreed upon, many holding firmly that it is basically psychologic in origin, while others concentrate on possible organic etiologies. Some psychiatrists and psychologists have even described mental illness as being a myth altogether, a tool used by The Establishment to further its goals. Many professionals regard mental illness simply as an expression of the Existential travail of Man.

It is understandable, therefore, that in this primitive state of affairs, many psychiatrists are discouraged and do not believe in the value of psycho-

therapy, nor do they practice it in any form. Nonmedical therapists have understandably rushed to fill the vacuum, and some have excelled in the field. Regardless of competence, their very entry into the private practice of psychotherapy and their treatment of an *illness* is facilitated by the existence of a nonmedical model of mental disorders. Karl Marx [9] observed as early as 1859, long before he became a poster and a banner, that "Men's social existence determines their values." In the light of this observation it is understandable why the nonmedical model is so popular, even if it is basically wrong and confusing. It obscures the all-important fact that emotional disorders are real illnesses that cause pain, chronic debility and death.

The incomplete understanding of mental illness and of the nature of psychotherapy, its logic and mode of action, is multiplied when the much more complex sub-specialty of group psychotherapy is considered. Several conscientious, honest and bright individuals have, nonetheless, laboriously constructed new theories from pieces of knowledge and then proclaimed their vision as being no less than the whole truth.

The situation is in many ways reminiscent of the famous story about the seven blind men who wished to discover the nature of an elephant. Their blindness prevented them from perceiving the totality of the beast, and instead, each was completely convinced, after carefully scrutinizing the part of the animal closest to him, that his description was both factually accurate and realistically correct. Such seven honest men must have been totally at a loss to understand how they could possibly comprehend the same animal in such totally divergent ways. To the extent that they were free of unresolved personal conflicts and hostilities, they might at least have listened to each other's description. With sufficient maturity and wisdom, such blind men would not dismiss a-priori as nonsense descriptions that were basically different from their own perceptions. As we know, but they could not, all of those descriptions had some truth in them. They merely represented different aspects of the total picture.

In our competitive society, men and women often wish above all to aggrandize themselves as discoverers of truth, and rational, cooperative efforts such as those the blind men might have been capable of, are few and far between. Perhaps that is one important reason why the project of elucidating a basic theory of individual and group psychotherapy often seems doomed to utter failure. Freud, Lewin, Perls, Berne, Lowen, Janov and others would probably not have wanted or been able to listen to and hear each other, had they had such an opportunity. Their partisan followers are surely totally incapable of doing so. Instead, complex theories are generally simplified, popularized, and held up by followers as the only truth, disdaining all others. It is safe to assume that each of the original contributors, from Freud on, would probably have disowned many of the practices that are so avidly proclaimed in their name by their followers. The

historical moment may finally be at hand for us to try fitting the different parts into a whole picture.

### THE PROBLEM

In the confusing field of psychotherapy, with multiple claims made by its varied practitioners, the mere definition of problems is a very real achievement indeed. An old, wise man of the East used to say that every good question contains important kernels of the answer within it. We must first ask what psychotherapy is, and define its basic assumptions and goals.

Psychotherapy is therapy, the process of healing, of the psyche. The psyche is an abstract term coined to describe the mental functioning of a person. Psychotherapy, therefore, is the process of healing or changing mental functioning of a person in the direction of health, with the goal of making his or her life less painful and more satisfying and enjoyable. A mentally healthy individual is capable of working and enjoying himself without spending excessive energy and without experiencing undue pain. The aim of psychotherapy is to help individuals reach such a goal. Those who avail themselves of what psychotherapy has to offer come because they encounter seemingly unbearable difficulties in living their lives in a satisfying manner.

A very important factor contributing to the confusion that clouds our field is the fact that patients present themselves with very vague and ambiguous complaints whose very identification and clarification is part and parcel of the psychotherapeutic process. In extreme cases, individuals do not even know that something is wrong with them, and consequently do not seek any help at all, and may refuse it when offered. In less extreme cases, a person may vaguely sense that something is wrong with him or her, yet be unable to identify, explain or even describe the nature of the difficulties. When the therapist himself is unable to recognize such vague complaints as symptoms of a real *illness*, he will tend to dismiss them as part of our Existential anomie or as an aspect of the Crisis of our Time. In such cases, the despair and desperation of patients is only increased, since they feel once more that their call for help, even if clumsily presented, is again not heard, but only explained away.

Another cause for confusion in the field of psychotherapy is that the incidence of mental illness is so great that *it*, and not mental health, is the mode of our society. Mainly as a result of the urbanization of our society, the depersonalization of work and the breakdown of the family, ego development is often impaired to a lesser or a greater degree. Vague insecurity and free floating anxiety are most common occurrences. The drug culture and the widespread use of alcohol could not have existed otherwise.

Masked depression is by far the most prevalent, if generally unrecognized, illness of our society. Since therapists of all persuasions are also a part and a

product of this culture, many of them are not personally exempt. It has repeatedly been demonstrated that therapists who themselves feel threatened by the symptomatology of their patients tend to gloss over and minimize such symptoms, or not see them at all.

A few more basic concepts need re-defining and re-emphasizing before we attempt to synthesize the various psychotherapeutic approaches into a single whole.

All psychotherapy, including group psychotherapy, is psychotherapy of individuals, not of groups. Group therapy is conducted in a group setting, but it is not the group that is sick, but the individual within it. It is he or she who suffers pain, or who has other difficulties when the internalized conflict has become characterologic. Individuals seek therapy and engage themselves in it as individual patients. Group psychotherapy is, therefore, somewhat of a misnomer, since the group does not have a psyche, nor internalized object representations. Groups may need to be changed structurally, economically or politically, but they cannot and need not be therapeutized or healed. Groups have a dynamic existence, and the members of a group may behave and feel quite differently than they do when they are alone. But therapy is related to an agonizing individual, and all theories of group psychotherapy that make any sense must, therefore, be derived from theories of individual therapy, and must be extensions of such theories. The many failures of group psychotherapy and group treatment in its various forms may well stem basically from a failure to understand this simple but all-important truth.

The hunger for closeness and for some form of meaningful human contact is so great in this society that all groups, whatever their underlying theoretical basis, hold out some promise of relief for alienated individuals, have wide appeal, and usually bring at least short-lived satisfaction to their participants. But they frequently offer no cure, and the good feeling is fleeting. The underlying illness is often not treated at all, the basic pathology remains unaltered and the patient reverts back to his or her pre-morbid self when the effects of the gratification are over. Such group experiences offer false hope and are analogous to benefits obtained from religious conversion. All ego-satisfying experiences are similarly helpful in the short-run. A happy love affair or the winning of a lottery can both be very helpful to a depressed individual. These, like the quick-cure, instant-intimacy group experiences are therapeutic. But they are not therapy. An aspirin may be therapeutic for brain-tumor pain. It is not therapy for such a condition.

The mushrooming and frequent discovery of new "therapies" in our field appears to be a direct result of the widespread disappointment experienced by both patients and therapists. The great promises of yesterday fall short in the light of day. It is as if each of the seven blind men has had a turn at describing his findings in a loud and clear voice before it becomes obvious that such a description cannot possibly coincide with the totality of the elephant. While

patients became psychologically wise and benefitted intellectually from very interesting insights, they often did not change characterologically enough to justify their great investments. Sensitivity training and the encounter movement were largely a reaction against the barren and super-intellectualized approach of psychoanalysis. They assumed that the expression of feelings, here and now, would in itself be curative. Such assumptions have never been proven valid, and in fact the presence of thousands of freely emoting patients in back wards of state hospitals everywhere proves such an assumption to be without a base. Bio-energetic analysis, Gestalt and various off-shoots such as Movement, Poetry, Scream and Sex "therapy" made their claims in turn. The current vogue, T.A., often turns patients into "trainees" and eliminates their need to own up to the unpleasant and painful reality of having to seek help for an illness. The human growth movement can attribute much of its popularity to a similar appeal.

Whatever the label or the disguise, the populations in all these groups, including psychotherapy groups, have been found to be basically similar, and to consist of individuals in search of relief from emotional difficulties. It is only natural and understandable that people with pain would tend to gravitate towards those approaches that seem to hold the greatest promise for the quickest help at the least cost, both financially and in terms of suffering. As disappointment follows disappointment, public cynicism increases and the public image of psychiatrists and other psychotherapists sinks to ever lower levels. Each successive wave of the then popular psychotherapeutic approach seems to be shorter lived than the previous one. Psychoanalysis was accepted for several decades, the encounter and sensitivity movement were at their crest for only several years. The life span of T.A. is likely to be even shorter. Its simple-to-understand explanations of dynamic conflicts within the person are substituted for necessarily painful working-through. Furthermore, when there is denial of the presence of an illness, there can never be, by definition, any hope for a real cure.

The disenchantment with psychotherapy as a tool for healing is shared by many psychotherapists. Some have attempted to show that the results of psychotherapy are not better than those achieved by spontaneous remission. A study of questionable validity to this effect is endlessly cited, quoted and brought up as proof by lay-writers and by frustrated psychotherapists alike. Some bitter therapists almost seem to delight in the claim that lasting results of experienced and competent therapists are not better than those achieved by inexperienced ones. Such studies, while possibly true, are cited not to prove the shortcoming of present day theory and practice but to justify the scrapping of serious psychotherapy altogether, in favor of "more promising" short-cuts. A few disappointed psychotherapists and others have adopted a philosophy of psychotherapeutic nihilism, and have given birth to an anti-psychiatry movement. Some psychiatrists and psychologists, unable to discover the basic defects

of psychotherapy as it is being practiced, have become social activists instead, discounting their own value as clinicians and as healers of the sick.

It is totally inconceivable to contemplate the existence of an anti-surgery movement among surgeons or an anti-baking movement among bakers. That such a strange phenomenon is to be found in psychotherapy reflects the deep disappointment of many of its practitioners, as well as their shame and guilt at earning a living from an activity that to many seems to offer little or no hope. Some therapists have even naively but seriously theorized that groups are therapeutic in themselves, and that the presence of a therapist is basically superfluous.

### THE THEORY

And yet, it is possible to postulate a unified theory of group psychotherapy that would find an appropriate niche for most of the new and old group psychotherapy approaches, and that would make coherent sense.

As claimed, a group might in itself have some limited usefulness in terms of helping isolated and frightened people socialize, and when used in a therapeutic context, be useful in releasing super-ego restrictions that are damaging to an individual. The group can act as a benign and permissive parent, taking the place of a restrictive and less flexible one, thus providing support for a struggling individual who attempts to release himself from a punishing super-ego. But, as Durkin [7], Spontnitz [10], this writer [1] and others have observed, the most important function of psychotherapy in groups is the provision of a forum for the working-through of pre-oedipal hunger that is at the root of most depressions and defects of the ego.

The concept of "cure" in psychotherapy, not even recognized as existing by many psychotherapists, simply means a successful completion of the process of separation-individuation. A mentally well individual is basically as mature emotionally as he or she is chronologically.

Feelings that emanate from unresolved needs of the past are often capable of swaying a person into actions that are no longer useful or justified by the reality of the present, but which are compulsively repeated. The therapeutic alliance with the therapist permits the patient to repeat within the transference the same conflicts that have normally hampered him in his other relationships, but to resolve them here more rationally. Traditional psychoanalysis holds that as the unconscious is made conscious, internalized conflicts are brought under the control of the ego, and as repressions are lifted the patient is able to deal more adequately with reality.

These basic concepts of psychoanalysis have proven true, but only in part. They provide a useful framework for understanding the psychotherapeutic process. However, since language, a late development of the infant, is the basic

or only means of communication in psychoanalysis, patients are often hampered in completing the working-through of pre-oedipal hunger that results from disturbances in the mother-child relationship in an earlier, pre-verbal period. Wise and correct interpretations by the analyst may be assimilated by the patient, but often without producing the desirable character changes. As millions of disappointed ex-patients of old and new therapies clearly know, it is much easier to become wise to oneself and to one's self-defeating patterns than to gain the ability to extricate oneself from them. When the unconscious is made conscious the work in earnest has just begun.

Adherents of sensitivity training and the encounter movement place the emphasis on the experiencing and expression of feelings in the here-and-now, in contrast to what they conceive of as the somewhat sterile and highly intellectualized exercise in self discovery represented by psychoanalysis. The highly cerebral involvement with the self in psychoanalysis is often used as a resistance against "getting in touch" with one's feelings, which may be painful. The new approaches were invested with magic powers by their proponents. Since making the unconscious conscious did not heal, the "honest" experience and expression of feelings surely would.

It was no more than a short misstep from advocating such expression of feelings to the taking of license for acting on them and for "doing one's thing." Verbal productions alone, it was claimed, had failed in psychoanalysis, therefore, gratification of repressed wishes was assumed to be curative. Such gratification is generally enjoyable, and it was, therefore, convenient to ignore the fact that it is rarely, if ever, beneficial. Also ignored was the obvious fact that such gratification guarantees failure in achieving long-lasting results in psychotherapy. The gratification of infantile wishes temporarily eliminates the pressure of underlying conflicts, and makes it possible to avoid or postpone the difficult task of internalizing new modes of feeling and being.

The yearning for the unreachable mother is frequently not resolved in psychoanalysis, since the relationship is not intensive enough to sustain the patient through the pain of mourning, and a depressive mood remains as a residue. The catharsis and gratification of infantile wishes that are commonly found in encounter and sensitivity groups, as well as in T.A., and occasionally in Gestalt and the scream therapies, similarly leave such yearnings in a permanently unresolved state, since a false promise of a reachable mother is promulgated.

By grafting the more desirable features of the new "therapies" onto the psychoanalytic model, an intensification of the affective involvement of patients in the process of therapy is made possible. Deprivation of infantile needs remains a cornerstone of the process of working-through, since it builds up a head of pressure within the patient. For similar reasons, catharsis, which lowers pressure, is best avoided. A therapeutic situation is constructed in which analytic neutrality is maintained, but with the emergence of the therapist as a deeply

involved, concerned and humane being. To achieve changes in character structure the therapist must be willing and able to become not only a transference figure but also an important, real person in the life of his patients, without encroaching on their freedom to grow according to their own values and inclinations. In an Existential sense, what the therapist is, is no less important than what he does. The details of his personal life remain unknown and obscure, his humanity does not.

Primal and other modalities of scream therapy [4] that are designed to help patients "remember" early life experiences physiologically may be incorporated into the basic model. As long as the scream remains non-cathartic, it helps create a situation in which affective memory is released from the body tissues. The patient is aided in bringing his or her observing ego to the integration of such affective memories, thus helping to lift the repression. Abreactive techniques are also used cognitively, and their abreactive element can be minimized [8]. Bio-energetic analysis similarly attempts to unlock affect that has been converted into hidden bodily expression. It is a useful tool in an integrated psychotherapy system for releasing from their bodily imprisonment feelings that are literally incorporated. They can then become available for conscious working-through. Gestalt and even certain T.A. techniques can be helpful in eliciting and intensifying the emotional experience of the patient in therapy and, as long as their limitations are recognized, may contribute to a successful psychotherapeutic outcome.

Any of these approaches, when used alone or as a panacea, is likely to allow patients to revert to becoming believers for a while, but will eventually bring forth unnecessary and painful disappointment. Psychoanalysis and T.A. are especially similar in the sense that many of their adherents tend to form "cult"-like loyalties with elaborate systems of beliefs and values. The rigidly hierarchial system that is followed by practitioners in both "movements" contributes directly, if unconsciously, to such irrational and child-like adherence. Rigidity of any type has never proven helpful in enhancing true conflict-free living for the individual.

The group therapist must develop special techniques for intensifying hidden and often disclaimed dependency yearnings and other strong affects in his or her patients. Such techniques must aim at creating situations within the therapeutic setting in which well-versed and well-tested pathologic modes of being will be challenged making it necessary for the patient to experiment with new modes of affective response. A temporary "knocking-out" of intellectual and other defenses is a requirement for the emergence of strong pre-verbal needs and fears. The situation thus created may well be termed a "Condition of Inapplicability" [5]: Although words continue to be used, their symbolic rather than their dictionary meaning creates the impact on the patients' psyche [1].

The aim of all therapeutic interventions on the part of the therapist in such a unified model of group psychotherapy is to apply a variety of psychologic

techniques with enough impact to produce physiologic changes within the patient. It is postulated that such changes are necessary for real character change. Patients have been "driven crazy" by their past experiences. They must be "driven sane" in psychotherapy. The process is painful, like surgery, and patients normally use resistance to avoid making the trip. As this author described more fully elsewhere [1] the group setting is the ideal one for applying special techniques for intensifying affect, since it provides conditions that allow for the splitting of the transference.

The best, although not a perfect, model for the psychotherapy situation is the surgical theatre. It is a repulsive and frightening model to many therapists, even to some with a medical background, probably because many psychotherapists somehow err in feeling that surgery per se is inhumane. Bettelheim [3] considered it important enough to write a book for psychotherapists reminding them that "Love is not enough," perhaps because of the protean nature of such misconceptions. The scalpel-wielding surgeon like the psychotherapist must, indeed, be free of personal hostilities that may interfere with his judgment or performance, but both must have the courage and skill to "cut" into the live body of the patient to remove pathological parts that endanger her or her very existence.

It is absolutely essential that the surgeon, even more so than physicians in other specialties, be:

1. totally devoted to the task,
2. totally competent,
3. deeply involved with the patient, but only in an objective, professional way, and
4. strictly observant of surgical technique.

The patient, on the other hand, after carefully checking the qualifications of the surgeon, must decide whether he can trust his life to the hands of such a person, regardless of any trepidations that may persist. The problem of trust in psychotherapy is more complex than it is in surgery, but patients have every right in either case to expect that both surgeon and psychotherapist spare no effort in seeing them safely through, even if it involves a great deal of inconvenience for the therapist. The commitment is a two-way affair.

The good surgeon, like the good psychotherapist, does not remain aloof nor uninvolved, but is deeply concerned with the welfare of his patient and with the outcome of his intervention. He must keep himself emotionally distant enough from the patient to preserve his objectivity at all times, but close enough to reveal his true presence and humanity. Psychoanalysts, on the other hand, often confuse the need for analytic neutrality with an apparent non-caring and aloofness, while the "feeling" therapists repeatedly substitute loving words and gestures for true concern. Unless the patient is a blind believer in a therapeutic system or in his guru-therapist, he is prevented from getting seriously involved in therapy if the therapist remains either too distant or unnecessarily close.

The psychotherapist, like the surgeon, must be more than just a compassionate human being, for it is not love but finely-honed skills that the patient needs to get well. In spite of Bettelheim's admonishments, many well-meaning but guilty and incompetent therapists fail to understand this basic concept. Good intentions, sincerity and humanism cannot take the place of clinical experience that sees through the defensive structure and knows how to deal with resistances.

Surgeons do not normally operate on individuals with whom they have important personal involvements, lest such emotional involvement interfere with the coolness of their judgment or the steadiness of their hand. Since the dangers and difficulties of the psychotherapeutic task are at least equal to those of real surgery, the psychotherapist, too, must retain enough personal detachment in spite of real involvement with his patient. This may sound most unacceptable and strange to those for whom terms such as "authenticity," "intimacy," "directness" and "closeness" have become rallying cries. Yet, in psychotherapy pain is real and no anaesthesia is used except for the comfort that may be derived from reality, and from the reality of the relationship with the therapist. Unlike surgery, the patient is fully conscious and aware during the entire process, and must endure the pain that is incidental to growing, changing and giving up undesirable parts of the self.

The patient in psychotherapy must never be deprived of his freedom not only to change but also to consciously refuse to. The rate of change in therapy as in surgery is dictated by the patient's own readiness for it, and by nothing else. Psychotherapists and surgeons are responsible for applying all the proper and available measures to expedite the patient's return to health, but they can and should do no more. When patients in either case appear to get well in order to please the therapist, their changes turn out to be unreal and usually short lived. In surgery as in psychotherapy, the patient must give the therapist permission to treat him, which in this model of psychotherapy means that the patient allows the therapist to "drive him sane," even as fear stares him in the eye. This is where the patient's trust in his own growing strength and the viability of the therapeutic alliance are put to the true test. The real joy of the therapist in seeing a crippled human being develop self-respect and a capacity and desire for self-fulfillment must never become a burden on the patient. It must remain a bonus that the therapist must not count on but only welcome when it comes.

Finally, the psychotherapist, like the surgeon, must continuously remember that during many phases of therapy the patient is extremely vulnerable to suggestions and to direct and indirect influence from whatever source. Very much as in the case of post-operative patients, the vital signs of psychotherapy patients must be carefully monitored regularly, and especially during critical periods, to detect important changes as early as possible. Newly found freedoms are sometimes used by patients without moderation or restraint before they can integrate them reasonably and without danger to themselves or to others.

Antiseptic techniques are used to minimize surgical casualties, and similar meticulous caution must be used with patients in psychotherapy. What may seem a minor fear or a small danger to the therapist is often regarded by the patient as being truly life threatening, or at least extremely frightening or embarrassing.

In effecting true character change the therapist, like the surgeon, must patiently but thoroughly separate those parts of the patient which are pathological from his healthy being, before attempts are made to cut it away. In more psychological terms, the patient's ego-syntonic psychopathology must be made ego alien before he can even consider giving it up. Infants frequently become panicky as they observe their bowel movement being flushed away; they experience it as an important part of themselves which is being lost. Patients often feel similarly frightened and become resistant when they experience therapy as endangering parts of themselves that they have always considered important. Psychotherapists, even more than surgeons, must be both sensitive and compassionate and yet quite firm and determined if they are to separate the patient from his emotional cancer.

### THE PRACTICE

Theories are as valuable as they are verifiable in the real world. Such verification must be capable of duplication by independent workers, separate from each other and from the originator of the theory. These fundamental principles of the scientific method have been applied strictly in the natural sciences, and they are directly responsible for the spectacular advances in modern physics, for example. In the inexact world of the social sciences, on the other hand, wild claims are frequently made, since no clear formulations nor formulas exist that make the testing of such new theories possible and feasible. Crisis Mobilization Therapy, C.M.T., is a recently developed psychotherapeutic system which incorporates the principles of an integrated model. It derives its value from its consistent integration of various elements and techniques into a workable whole. C.M.T. is presented here in outline form as a psychotherapy model that is testable against the theory.

The basic assumptions of C.M.T. that need to be verified and confirmed are that a real cure for most forms of mental illness is achievable by its approach; that a psychotic-like core exists in all individuals and that it is changeable by psychologic means of sufficient intensity; that incompleting psychologic weaning is at the root of most depressions, overt and masked, and that the process of separation-individuation can be successfully finished in C.M.T., thus filling life-long hungers from within.

These assumptions plus several additional ones must now be tested by comparing specific C.M.T. techniques [2] to the theoretical outline, and by direct observations over time of its practice by therapists with special

competence in its use. Both methods must be pursued by objective outsiders with sufficient sophistications, mental health and emotional freedom to come up with scientifically valid data.

Only a few points about C.M.T. need to be made in the context of this discussion. It attempts to re-create situations in the therapeutic setting that give patients an opportunity to re-experience their emotional conflicts at crisis points of maximum tolerable anxiety, and then it brings their observing ego into the process of working-through. Various provocative and evocative techniques are used to overcome resistance which often is extreme.

The viability and strength of the therapeutic alliance is always being tested. The therapeutic work frequently occurs at the Point of Tolerance, and much skill and intuition are required on the part of the therapist to gauge correctly the limits of such tolerance. He or she must refrain from exceeding such limits, for if the threshold is exceeded the patient will emotionally faint, block out all feelings or get confused, leave the room temporarily or leave therapy altogether, all representing regressions to more primitive defenses. Others may experience a temporary flight into health. Affect is mobilized and brought to a crisis point again and again, until it no longer assumes the dimensions of a crisis in the life of the patient.

Crisis Mobilization Therapy is an attempt to construct a psychotherapy model, most appropriately used in combined individual and group psychotherapy, according to the principles that make theoretical sense. It will probably require further modifications as our understanding of the intricate workings of psychotherapy expands and deepens. Yet, the fog of confusion seems to be lifting. To the extent that the claims made for C.M.T. are valid, a vague outline of a whole elephant is beginning to emerge. Its lines are likely to become sharper as we define more clearly the meaning of progress and the concept of cure in individual and group psychotherapy.

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