DOCUMENT RESUME

ED 102 479 CG 009 580

AUTHOR Azima, Fern J.
TITLE Effective Communication in Adolescent Group Psychotherapy.
PUB DATE Aug 74
NOTE 18p.; Paper presented at the Annual Meeting of the American Psychological Association (82nd, New Orleans, Louisiana, August 1974)

EDRS PRICE MF-$0.76 HC-$1.58 PLUS POSTAGE
DESCRIPTORS Adolescents; *Communication (Thought Transfer); Counseling; *Group Counseling; *Individual Development; *Psychotherapy; Research Projects; Speeches; *Verbal Communication

ABSTRACT

This paper defines a useful strategy for therapists working with adolescents which includes: (1) a general model of the group leader's responsibilities and (2) a cataloguing of some of the specific impediments for both adolescent peers and the therapist that prevent effective communication. The goal of the group therapy is to identify the specific impediments and distorted transference relationships. Unlike conventional leaders the group therapist makes no bid for power. He searches out the silent and negative members spontaneously and, at the same time, is concerned with the group as an effective growing unit. The problems encountered in this context are those of peer transference and leader countertransference as barriers to effective communication. Some transference themes described are: attitudes toward authority and peers; acting out; silence; and somatization or the technique of handling stress by somatic symptoms. Conversely, countertransference reactions of therapists are listed: omnipotence; fear of self-disclosure; overidentification with the adolescent; or somatization and blind spots, i.e., the therapist becomes alerted to his own anxiety or depression by symptoms such as headaches, flushing, nausea, cramps. In summary, the paper presents a general model of the effective group therapist and his major responsibilities for both cognitive and positive emotional leadership. (Author/RJ)

ED102479

BEST COPY AVAILABLE

EFFECTIVE COMMUNICATION IN ADOLESCENT GROUP PSYCHOTHERAPY[1]

Fern J. Azima, Ph. D.[2]

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

1. Paper presented at the 82nd Annual Convention of the American Psychological Association, New Orleans August 29 - September 3,1974.

2. Associate Professor, Department of Psychiatry, McGill University, Montreal, Canada.

Effective communication in the context of this presentation is meant to be the intellectual and emotional dialogues verbal and non-verbal amongst peers and therapist that are reciprocally understood, accepted, and that lead to better coping behaviour on the part of the disturbed adolescent. Much 'talk', explanation and interpretation that may appear particularly wise from the therapist's point of view, may be ineffective if it does not correspond to the needs of young members in the group, i.e. if the communication does not penetrate and touch the core of the problem. In the long run one judges the effectiveness of the therapy communication by the attendance /or lack of it/, the gradual building of group cohesion and loyalty and changes in the group members that generalize the home, school, friends, and community.

The process of a well functioning group leads to the gradual building of trust, and intimacy that permit the risk of self disclosure, critical self examination and the search for new solutions to reoccuring problems.

There appear to be certain general requirements for effective group leadership as well as other specific communication difficulties that are encountered by therapists who work with adolescents. A useful strategy for therapists working with adolescents would be to define: 1) a general model of the group leader's responsibilities; and 2) to catalogue some of the specific impediments for both adolescent peers and the therapist that prevent effective communication. The goal, then, is to identify the specific impediments and distorted transference relationships and

to strive to alter and modify them sufficiently so that each member can participate in an open dialogue, maintain greater pleasure and self esteem. From the methodological point of view the therapist combines the interaction pattern of each member, the styles of initiation and reciprocation in the social matrix hierarchy, and the modification of the specific communication distortions for each member.

1. A General Model of Group Leadership.

For some time there has been a heated controversy as to the qualifications of an effective group therapist. Some have stressed the cognitive factors: (interpretation and working through) and others the emotional warmth and empathy (cf. Truax) of the leader as being the major curative factors. It is, however, the therapist's actual interactive mode in the group that mirrors how he thinks, feels and how he deals with distorted information and how he encourages members to feel less negatively and to problem solve more accurately. Unlike conventional leaders he makes no bid for power, his status does not have to be maintained by overbinding group members to him. He searches out the silent and negative members with the understanding that they cannot "repay" his initiations. At the same time he must be concerned with the group as an effective on-going, growing unit and makes timed references to the group as a whole. There is much evidence to support that the therapist is a major builder of friendliness and group cohesion, while never forgetting his job of undoing faulty distortions and defences and to allow the group to experiment in the present reality with new coping patterns that bring praise and growth

in self-esteem. As the peers modify roles and status in the group they assume greater influence, responsibility and independence in working through their own problems.

II. Specific Communication Difficulties in Adolescent Groups.

In a strict context the problems of peer transference and leader countertransference are the essence of the marked difficulties that hinder and block ineffective communication. Transference as such may be described as the repetitive, unconscious, emotionally significant manifestations of patient behaviour in relation to the therapist, to other group members and to the group as a whole. "From this point of view transference stretches horizontally in the present and vertically in time, and integrates both intrapsychic and interpersonal phenomena. The multiplicity of interrelationships in the group structure identifies a different monitoring system, and alters significantly the reflective attitudes of reciprocating patient and leader" (Azima 1973). Countertransference may be defined as the therapist's repetitive, unconscious motivated, conflictual response to the individual patient or to the pressures of the group as a whole. The therapist who has an overabundance of such irrational communications cannot deal objectively or effectively with the group. At the same time it is inconceivable that some manifestations of countertransference reactions are not alerted by the adolescent culture. With this proviso, the following examples are termed as transference, inasmuch as they stem from past, unconscious, distorted reactions which are repeated and reactivated in the here - and - now, and continue to hinder the socialization process.

A. Transference Themes in Adolescent Groups.

This discussion will briefly review: attitudes towards authority and peers, acting out, silence and somatization.

1. Attitudes towards Authority and Peers.

In an early group session the following dialogue took place.

Member 1. Why should I go to school. The courses are lousy, they don't interest me, and the teachers are always on my back.

Member 2. I agree, they sit so smugly, worrying only about their paycheques and not us.

Therapist. And here - you expect the same?

Member 1. Well, you should know better.

Member 3. But I do like the fact that here I can listen to the opinions of kids my own age - and the group is exclusively for us, and my parents can't butt in.

Therapist. You are all probably fearful and distrusting for good reason, and worried whether your parents will control you as in the past. I can't promise that everything will be perfect here, but remember it is not your home or school here and we have a chance to size up if we are seeing things clearly.

The therapist's response above was an attempt to prevent an identification with the nagging parent and to orient them to the here - and - now and to set the goal of reclarification. It is of some interest to note member one's change over the last 5 months. This 16 year old, intelligent, passive-rebelling girl had been out of school for the past 6 months. In a recent session she said.

Member 1. I really am surprised how much better it is at school and how well my work is going. Even that bloody principal smiles at me differently.

Member 2. Fantastic, and how about at home?

Member 1. Even with my father it is 100% better, when I say how was work to-day, he really knows I mean it and really talks "to me".

Member 1. (Cont'd)

> I'd like to tell you that my kid brother who has the learning difficulties came home the other day after a gym day with a lot of ribbons. I was glad for the ribbons, but I really was happy for him. For the first time I could feel something else except rage and jealousy.

Therapist. Even as you talk now we all can see your spontaneity and your pride. It is a lot different than when you were so distrustful, angry, and moody.

Member 3. I wish I could relate to my family the same way. I just hate them.

The above vignettes demonstrate how one member has lifted some of the blocks in communication in the group, in her home and at school. She has become a highly influential member encouraging others to risk "opening up" and setting new goals. The therapist must accept anger, criticism without becoming irrational and overemotional as have authority figures in the past. However, it is very important to recognize that the therapist must not join in the open rage against the parent. If the therapist condemns the parent the adolescent will retaliate by breaking treatment. One admits that many authority figures have marked difficulties of their own but they are not in the present treatment group and the goal is for modification in their own behaviour to improve communication with others on more independent, less distorted levels. The improving adolescents become (as Member 1 above) co-therapists.

An example from a session in the fourth month is illustrative of libidinal peer transference behaviour. Bruce was a tall, blond, sulking, self-centered boy who always sat with his jacket on. He rarely listened to others, always believed he was right and the authority in all areas.

It was clear there was some ambivalence between Bruce and Claire, a most attractive, dark-haired girl who sighed derisively every time he began his boastful exposés.

> Bruce - "You are just the kind of rich snob I can't stand. So much makeup, and look at your clothese and your jewelery. Those rings and watch. I can just see you brushing every guy off like dust."
>
> Claire -"You are stupid. - Rich - ha - my mother is a maid and I've got nothing to be stuck up about. I'm even an illegitimate child."

The group members pointed out that he was really attracted to Claire, but that he was afraid she would not give him a tumble. The therapist at this early stage did not interpret this adolescen't constant fear of rejection, (his mother would not keep him) and his fragile sexual identity. (He had been picked up by the police for homosexual loitering). It was clear to the group that this attack was distorted and revealing of his past unresolved problems.

2. Acting Out.

Adolescents are known for their normal capricious acting out and this in itself alerts many rigid therapists to become very defensive in dealing with teenagers. What is of more importance from the psychotherapeutic point of view is to identify the transferential compulsive acting out and repetitive defence based upon a variety of historical unsatisfied needs.

Nancy, an 18 year old, talked openly in the group of her sexual acting out, chronic use of hard and soft drugs, and her numerous suicidal attempts. She was an intelligent, powerful group member who was highly skilled in identifying and interpreting the

behaviour of other group members. In several sessions she threatened to leave the city. At the same time she had taken to telephoning various members in the group. In one specific session the following conversation took place.

Nancy: Yes, really I am going to leave. I can't keep up the apartment, and my parents are throwing a fit about my relationship with Dick.

Bob: I think you are copping out again. You've tried every hospital, doctor and social worker. You really are an important member to the group. You always help others but not yourself, and you are not giving us a chance to help you.

Group: Many agreeing statements.

Claire: My mother got another phone call and she said it was somebody from the group.

Nancy: No, it wasn't me this time - honest. I have phoned you before.

Many: But you did phone me.

Sid: And me.

Therapist: Nancy you seem to be kind of playing therapist outside of the group, and getting many people on your side. Do you think (addressed to the group) that she could be recruiting members to join her if she leaves the group?

There began an active discussion in which Nancy admitted her constant fear of getting involved anywhere for the repeated danger of constantly being abandoned. She resisted with defiant determination that she could be helped. In fact this patient left the group for a month, but returned downcast, admitting guilt that one of the boys in the group had visited her but she had resisted. This is a high risk patient whose self-destructive acting out is a constant danger for the group

and encourages dependency and overprotection. At the same time she must be confronted with her anger. As Mary told her recently: "You are just plain dumb and how long can you act this way?" The therapist commented that Many was so angry because Nancy had helped so much in the past, and was not letting her to reciprocate.

Sometimes a powerful group member exploits a weaker one to act out her defiance, as for example when a girl threw the darts at the therapist at the provocation of another (see Azima, 1973). In this instance group pressure "saved" the therapist and helped expose the real culprit.

Body language and non-verbal behaviour communicates a wide variety of acting out e.g. head slapping, lighting matches and actually burning fingers and clothing, scratching the furniture etc.

Cultural patterns have changed considerably in the last twenty years. Previously many adolescents were excessively shy, inhibited and guilt ridden. Schizoid adolescents still behave in this fashion, but the majority feel justified to act, disagree, to fight the establishment and no longer to sulk in silent rage. Encounter techniques are not needed for this group in fact the need for control over primitive drives is often requested by the adolescents themselves.

3. Silence.

Silence is poorly tolerated by adolescents in the group, even though they are the most excellent utilizers of this technique with parents and teachers. "Keep cool - give them the stony eye - - not a word - not a flicker of interest" - This routine is highly successful in raising the anger of the authority and the therapist must not fall into this trap.

Silence is a resistance that clothes a variety of transferential fears, e.g. "I was afraid if I talked about what I did I would be the sickest person here" (the patient walked in cemeteries in the dark of night collecting all the stray cats). For several months this obese girl sat with her coat wrapped around her. On the day she took her coat off the therapist asked if she was ready to "open up" and she smiled and said yes. (Five years later she is a highly competent nurse).

Another boy broke his silence after several months in a heated discussion of drugs. The therapist stated: "No one gives up drugs if they really are greater than any other experience you can have." Stan attacked the therapist, saying that I should "warn them of the consequences". The group quickly alerted, asked Stan how he was so knowledgeable - and Stan answered: "I'm a nark (narcotics agent) planted by the police in my school - and I've been afraid to tell you". The group was silent and then asked if he was informing on them. Stan quickly said - "Of course not, I hate the job, but it's the only way I can deal with my father." It soon became clear that he became a more super detective than his military father. It was one way to have power over him and to disguise his own rebelliousness.

Many silent members talk with their eyes, a glare, raised eyebrows, mumbling, wincing, pursed lips, raised shoulders, tapping fingers or toes. To the latter behaviour a therapist once caught a silent member off-guard by asking - "What did you say - I didn't understand your morse code." To which the member responded - "You're right, I do have something to say."

A trap set by silent members is that other talkative peers and therapist do the talking for them. In this way the silent member never has to be responsible for the decisions made for him. Some therapists maintain that silent members do really get something from the group. A few may profit, for unless the patient regains the use of language and participates there is no evidence of change. The transferential reasons for silence range from the defiant, sulking child, sadness, defiance, anger, fear of loss of control, fear of giving etc. Many times a silent member wields significant power in the group and frequently is encouraged covertly by peers not to talk to act out a group resistance whether it be sadness, rage, fear, etc. He is asked to be the hold-out for their own defensive fears.

4. Somatization.

The technique of handling stress by individual members is usually seen by the somatic symptoms actually seen or discussed in the group. Fainting, hyperventilation, headache, sweating, asthma attacks, palpitations, seizures, encopresis, vomiting, are but a few seen by the author. Often both patient and therapist cling tenaciously to the discussion of the symptom as a defence to prevent coming to grips with emotional problems. In my own experience adolescents are not as preoccupied with somatic symptoms to the degree of adult patients, and their wish is for health not illness.

The therapist's technique may be seen from the following example of nail-biting: Ann sat biting her nails as Bob watched her.

Bob: You bite them?

Ann: Yes, I like to.

Sandra: You suck them?

Ann: No, I eat my nails.

Therapist: You don't chew them down very far - they don't even bleed.

Ann: No, I don't like to hurt myself.

Sandra: Have you tried to stop?

Ann: I can't.

In this example the therapist demonstrates how she allies early in therapy with the impulse, is not perturbed, and allows the patients to verbalize without fear of parental chastisement. The peers soon discover that there is no active witchhunt against symptoms and they disappear as tension, anger, and loneliness decrease.

At times hyperventilation, asthma attacks, running to the toilet, feeling sick occur in the group when relevant transferential figures are discussed or "taboo" topics that the members have not been able to reveal.

A common feature of all transference reactions is the defensive nature of continuing to raise patterns of behaviour to prevent self--disclosure of their bad and sinful thoughts and feelings. Once these are exposed and the patient is not ostracized or rejected or the feared catastrophe does not result they experience relief from symptoms, gratification and acceptance.

B. Countertransference Reactions of Therapists.

Countertransference reactions in therapists are often quickly mobilized by adolescents who invade their privacy, show lack of respect, attack, and "fool around". Beginning therapists often complain that adoles-

cents are not serious enough, and miss that the essence of adolescent communication is contained in this playful, acting out defiant behaviour. Therapists unwilling or unable to be in touch with their own adolescent feelings do not enjoy the expressing of their own spontaneity, and become overserious and rejecting and intolerant of regressive behaviour of the patients.

"The dilemma clearly posed for the therapist working with adolescents is how to maintain an intermediate position in the chronological and maturational ladders; he will never be accepted as a peer, and he should not retreat into an autocratic judgemental role." (Azima, 1973)

Some therapists are further ineffective communicating with adolescents in that they have low frustration tolerance for anger, acting out for fear that it will unmask their own adolescent rebelliousness. They stifle the group and overdemand conformity. The overscientific status approach is often a way to mask fears of shame, inferiority, and helplessness.

Many therapists are helped in supervision in overcoming their unrecognized countertransference reaction. The interrelated issues of omnipotence, fear of self-disclosure, overidentification with the adolescent, somatizations and blind spots will be very briefly reviewed.

1. Omnipotence.

Omnipotent therapists encourage dependency and prevent autonomous growth. The therapist who needs to be too brilliant, and too powerful prevents the patient from seeking solutions for himself and quite frequently causes withholding e.g. "since you know everything even before I say it, why bother". The therapist is afraid to look weak

and vulnerable, he is unable to admit he can make mistakes. His overperfectionism blocks competition since the adolescent soon senses that if they "argue" or disagree the therapist's narcissism will be hurt. At the same time the omnipotent overambitious therapist insists on the "best group", the fastest cures, and cannot tolerate failure easily.

It is important to note that the adolescents in the early stages of treatment push for an omnipotent all-saving therapist. Therapists who cannot admit their limitations will maintain dependent helpless patients. The transferential dream of regaining the perfect parent or saviour must be exposed. Omnipotent therapists may vary from being exhibitionistic and overly assertive on the one hand, to being overly silent, distant, mysterious and maintaining the image of the silent sage and the only one in the group possessed with the capacity for understanding.

2. Fear of Self-disclosure.

All group therapists have become more active in group interaction in the last decade. The dilemma is clearly that the more active the therapist becomes the more he self-discloses, and becomes vulnerable. The professional, distant calm of the overneutral therapist is a way to keep in check exposure of his own aggressive and libidinal drives. The therapist who must overprotect the public image of himself is usually too rigid, fearful, and raises the anger of the adolescent.

A well known defence overused by therapists in the past is to answer a question with a question, especially if it is one that encroaches on his privacy. Adolescents are highly skillful in such invasion tactics. The calm flexible therapist answers many questions about himself and draws a line at the point where he wants no further encroachment. The fifth amendment rule, is a good safeguard for both therapist and

peers to protect their personal selves under the attack of group pressure.

3. Overidentification with the adolescent.

At the other extreme some therapists develop an overcloseness and intimacy with the adolescents, almost as peers. At first, adolescents also like the 'good guy' approach, but soon they will become alarmed by the overcloseness and the often implied seductiveness, voyeurism and become aware of the therapists' vicarious need to relive their own adolescence. Starting with overidentification therapists have difficulty in setting an adult model to which the adolescent should maturate.

Adolescents quickly manipulate the overly permissive hippie therapist who can set no rules.

Sometimes, it is quite difficult to see that some quiet conservative therapists are involved in such overidentification with the adolescents. The following example may be illustrative. Two analytically oriented therapists started a group in a home for delinquent boys. They were quiet, neutral, attentive, and showed little emotional response to the anger of the boys. Their leaders did state that "some of the rules and regulations here are difficult". In the third session the boys destroyed the entire group room. In supervision it became clear that the therapists had given the message that they were on the boys' side and against the "establishment". Since they set no rules or gave emotional response themselves, they gave tacit assent for the boys to escalate their anger and to viciously act out their own desires to get rid of the bad place.

There is no such thing as completely neutral behaviour. Every therapist communicates even by his "hmms", his shrugs, his body geography, his eyes whether he is in agreement, disagreement, and if he wishes the conversation to continue.

Sexual countertransference may underlie some of the therapists' difficulties and are disguised by his coldness, vagueness, or openly evidenced by his overconcern. The therapist must be secure enough in his own sexual role not to become overly provocative or seductive, or at the other extreme a cold fish. Spontaneity and a good sense of humour are important parts of the therapist's emotional repertoire with adolescents.

4. Somatizations and Blind Spots.

The therapist becomes alerted to his own anxiety or depression by symptoms such as headaches, flushing, nausea, cramps, urinary frequency, etc. Yawning and falling asleep may be due at times to fatigue, but most often when analysed are related to flight from anger and attack.

Therapists only become aware of their blind spots by either being observed from behind a one-way screen, or in group supervision when peers identify behaviour which has not been otherwise reported. A supervisor who listens only to retrospective reports or audiotapes is often significantly surprised when he watches his supervisee on video or in reality.

In conclusion the paper has had the goal of presenting a general model of the effective group therapist and his major responsibilities for both cognitive and positive emotional leadership. In addition some

specific transference reactions for adolescents and countertransference reactions of the therapist were outlined, which impair communication. It is felt that this cataloguing may be helpful to the therapist who wishes to promote effective communication in adolescent groups.

In addition, however, to adequate skills and experience, and a minimum of countertransference reactions, certain personality characteristics in the group therapist appear essential and those include spontaneity, enthusiasm, optimism, trust, honesty, a sense of humour, and affection and belief in the integrity of the young.

REFERENCES

Azima, Fern J. (1974). Behavioural Indices of Individual and Group Dynamics, International Journal of Group Psychotherapy, in press.

Azima, Fern J. (1973). Transference - Countertransference in Group Therapy for the Adolescent, etc. N. S. Brandes, and M. L. Gardner, New York: Jason Aronson Inc. pp. 101-126.

Azima, Fern J. (1972). Transference-Countertransference Issues in Group Psychotherapy for Adolescents. International Journal of Child Psychology, 1, 4, 51 - 70.

Bales, R. F. (1950). Interaction Process Analysis: A Method for The Study of Small Groups. Cambridge, Mass. Addison - Wesley.

Psathas, G. (1960). Interaction Process Analysis of Two Psychotherapy Groups. This Journal, 10, 430 - 445.

Talland, G. A. (1955). Task and Interaction Process: Some Characteristics of Therapeutic Group Discussion. Journal of Abnormal and Social Psychology, 50, 105 - 109.

Truax, C., and Carkhuff, E. (1967). Toward Effective Counselling and Psychotherapy. New York. Aldine Publishing Co.