THE JANUS FACE IN GROUP PSYCHOTHERAPY

Gerd H. Fenchel, Ph.D.

Combined therapy offers the practitioner a rich data field for observation and research. Seeing the same patient in the group and in individual analytic therapy raises certain questions such as how differently does the patient present him- or herself, what does the difference or lack of difference mean, and is it prognostically meaningful. Based on ego theory, the author hypothesized that different therapeutic environments ought to evoke different levels of response. This adaptive quality was thought to be prognostically significant and indicative of a greater possibility for structural change. A small clinical sample showed a tendency in that direction.

The head of the Roman god Janus, custodian of the universe and the guardian of gates and doors, was represented with two heads set back to back. This is a useful image to symbolize a set of issues of interest to therapists treating patients in combined therapy. Can we expect different faces from patients in combined group and individual psychotherapy? Do different contexts evoke different responses from a patient despite the fact that his or her basic dynamics remain the same? What might it mean if a patient is like Janus in combined therapy, namely, presenting a different face in each modality? What might it mean if the patient doesn't? Does one patient have a better prognosis than the other?

Therapists who prefer to treat patients in combined therapy do so out of the belief that each modality provides a different therapeutic experience for the patient. Those who conceive of treatment from the perspective of ego psychology, for example, assume that patient's responses and reactions will differ depending upon a tendency to adapt to a changing environment, and they hope to elicit varying adaptational styles from patients by placing them in two therapeutic environments. Hypothetically, this provides an opportunity to broaden and enrich the therapeutic process. Nevertheless, clinicians have found in combined treatment no particular guarantee of therapeutic effectiveness. The aim of this paper is to take up two questions: 1) What makes combined therapy successful for a particular person? 2) What can be learned from those patients who seem to benefit from only one modality or the other?
Previous studies have focused primarily on the therapeutic efficacy of one modality over the other. Toseland and Siporin (1986), for example, studied the literature looking for differences between individual and group therapy in the same problem areas. They could not find clear patterns but showed that in 75% of the cases, group treatment was as effective as individual treatment and was more effective in 25% of the cases. A more sophisticated study by de Carufel and Piper (1988) examined factors that might account for short-term and long-term treatment effectiveness in either individual or group therapy. Some of the variables studied were: (a) object choices; (b) quality of relationships; and (c) types of sexual relationships. When separating improvers from nonimprovers, the predictors of "object choices" and "quality of relationships" reached levels of statistical significance. The type of interpersonal relationships formed by patients also differentiated them whether they were in short-term group or in long-term individual therapy. But none of the 15 variables studied predicted improvement in one type of therapy and nonimprovement in the other. There were weak indications that people highly motivated for individual therapy did better in that modality than in long-term group therapy and that patients found to be likable were more often seen in individual rather than in group therapy.

Clinicians have also been concerned to find distinguishing factors that would explain why some people were more amenable as group patients than others. Winnick (1965) stressed that for improvement to occur, members had to make the group their common reference point. Similarly, Hulse (1960) remarked that group effectiveness decreases to the extent that the patient's problem is special. Fisher (1960) added that negative transference and an unfacilitating environment should be included in making such predictions.

Saravay (1978), on the other hand, takes up the more general question of what makes for therapeutic change. He feels strongly that it is brought about by new identifications. Identification might become extremely difficult when the group composition includes borderline and narcissistic patients. Some claim entitlement for past injuries in their lives and want special treatment. And some want to be deeply understood and resent the attention paid to others.

Obviously, group therapy is not a substitute for individual therapy. The painstaking work of analysis must be severely modified or even somewhat neglected in the interactional environment of the group. In the dyadic relationship we minimize external stimulation for the purpose of self-reflection. In the group setting, we encourage external stimulation to facilitate communication and interaction. What are the implications of this and subsequent effects on the patient?

This clinical study is based on an intensive in-depth exploration of seven long-term patients (Hennie, Lenny, Elise, Richard, John, Karen, and Charles) who have been in combined therapy with the same therapist. Some of these patients evidenced a Janus phenomenon, some dropped out of either individual or group therapy, and one terminated all therapy. Most patients improved and altered their life situation, but they varied in the degree to which they could modify maladaptive character traits.

CLINICAL VIGNETTES

Because of space limitations only four of the seven patients studied will be presented here. These particular patients clarify the issues. They present a poignant and dramatic illustration of how they reacted to a changed environ-