Terrified of Group Therapy: Investigating Obstacles to Entering or Leading Groups

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Despite substantial evidence that group therapy is effective, many individuals are reluctant to join groups, and clinicians are reluctant to refer patients to them or to lead a group themselves. This article investigates the obstacles to participation in group therapy. It focuses primarily on the deeply personal elements of this hesitation for potential group members, which include social anxiety, fear of anger from other group members, dread of experiencing shame or humiliation, and desire for individual attention. Clinicians, as well, are reluctant to lead groups, because they feel insufficiently trained and may fear the experience of inadequacy, shame, and humiliation. These obstacles to participation are often driven by powerful components of transference and countertransference.

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> I am beset, too, by obsessively remembered thudding guilts and scalding shames. Small potatoes, as traumas go, but intensified by my aversion to facing them. (1)

Damien, a patient with social anxiety, replied to his therapist's suggestion to consider group therapy as an option, "I could never be in a group and talk with strangers about my innermost thoughts. That's not for me." Damien's individual therapist, who also viewed group therapy as potentially challenging for Damien, persisted because she recalled that residency supervisors had identified group therapy as best practice for social anxiety—even though she was certain she would never lead a group.

Damien entered the group reluctantly, and the group, comprising seven other members of a mix of genders, greeted Damien amiably. He would be most comfortable, he said, if the group members took turns introducing themselves, and they did. But the final member, known by the others, but not by Damien, to be provocative, said, "I have no interest in doing this for the new member, so I'll pass." Immediately feeling shame that he had violated some protocol, Damien reddened and said, "I'll pass also, until next week." But he had quickly decided this would be his last group session.

When the individual therapist heard Damien's report, she questioned her decision to refer him and concluded, "I guess group therapy is not for you." The therapist, an avid moviegoer, had seen multiple therapy groups gone awry in films:

> If it's not the chair thrown with such force by Michael Keaton in *The Dream Team* that it actually sticks in the wall, it's the chair violently tossed aside by Paulie in *The Sopranos* as he crosses the room to knock Christopher on his behind. Or it's the gigantic chair shaped like a baseball glove in *The Color of Night*, bowled over by one group patient who lunges murderously at another. (2)

The therapist seems to be unconsciously colluding with Damien's fear of aggression, shame, and rejection rather than helping Damien to regulate and process these intense feelings, which might have led to a return to the group. Moreover, a therapist who refers a patient to group therapy may have to combat internal fears, such as concerns about potentially losing the patient, exposing his or her own clinical work to another practitioner, or working at cross purposes with the group therapist. All of these factors serve as additional barriers to referral.

For a variety of reasons, most entirely understandable (e.g., avoidance of the shame Damien felt and of the situations depicted in movies or TV), many therapists do not practice group therapy. Some may even experience anxiety or terror at

HIGHLIGHTS

- Most individuals are reluctant to enter group therapy, and many therapists are reluctant to facilitate group therapy.
- The hesitation to enter a group arises from myriad factors, including social anxiety, fear of anger from other group members, fear of shame and humiliation, and desire for individual attention.
- The hesitation to lead a group arises from lack of training, fear of inadequacy, and fear of shame and humiliation.

the idea. Certainly, a large number of prospective patients experience that terror with regard to joining a group as well. Although it is true that group therapy, like other forms of therapy, can have adverse outcomes (3, 4), the typical patient, and even the typical therapist, will most likely not experience an adverse result. So, why the terror?

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The research literature has established the definitive benefits of group therapy (5–7). These include engaging in relationships in the here and now; having opportunities to observe and change relationship patterns; working through parental and peer transference interactions that occur in real time; using the group matrix to try out new relational behaviors and receive feedback from others; learning to be accountable for one's actions; and reducing isolation, alienation, and shame by sharing experiences with caring others.

Despite these established advantages, the reluctance to enroll in group therapy endures. An underlying anxiety remains that prevents potential group members and leaders from participating. I will briefly review some of the reasons that potential group members have been hesitant to join and potential leaders have been hesitant to lead group therapy. These data arose from multiple therapists and from multiple patients in my practice and in those of my colleagues and supervisees. I will then turn to my central thesis that a powerful driving force lies at the heart of this hesitation, one so powerful it often resides just beneath the surface of awareness. Even some experienced group therapists are subject to the same force. Yet the very nature of group therapy can offer an antidote to this force, as the reader will see in the case example of Samantha, a young mother, which appears below.

OBSTACLES PREVENTING INDIVIDUALS FROM ELECTING TO JOIN GROUP THERAPY

Someone seeking therapy may not want to engage in group therapy for a variety of reasons. Many people prefer individual attention from a therapist, but in group therapy, the patient must share the therapist's time and attention. For some, this type of sharing feels too depriving and painful. Additionally, to be heard in a group, one often must ask for attention, and this declaration is foreign to some patients who, driven by projection and transference, anticipate that others will not find them worthwhile. Others, harking back to the stranger anxiety felt by young children, experience a sense of "stranger danger" caused by fear of being harmed, evaluated, or judged. For many people with social anxiety or insecure, anxious, or avoidant attachment styles, this danger feels even more immediate. Those who have experienced developmental trauma as children as a result of feeling harmed, rejected, or invalidated will predictably fear reenactment of this relational failure in the group context.

At the heart of these fears is a compelling, if not controlling, fear of being shamed or humiliated and appearing emotionally naked in front of others. This shame is present in many patients who seek individual therapy for anxiety or depression (8) and who experience negative therapeutic reactions within the therapy (9). Imagine how this fear of shame may be magnified in group therapy (10).

Damien, like many patients, preferred the protective bubble of the individual therapy relationship. As Alonso and Rutan (11) have so eloquently suggested, "Given the fantasied blissful relationship of a maternal dyad that persists in our culture as the ideal symbiosis, it is always a challenge to present the patient with group therapy as a full-fledged treatment model on a true par with individual treatment."

OBSTACLES PREVENTING INDIVIDUAL THERAPISTS FROM ELECTING TO LEAD GROUPS

As many readers are aware, some therapists are reluctant to lead groups. In their training, many individual therapists are exposed to some form of group therapy, such as co-leading a group with a more experienced therapist, leading a group alone in a clinic setting, or participating in an experience group (often called T-groups) led by a senior group therapist. Rarely, however, does this exposure motivate therapists-in-training to add group therapy as a modality in their arsenal. What stops individual therapists from adding the modality of group therapy to their repertoire of clinical interventions? Although some of these barriers are structural, many are psychological and can be understood and surmounted with consistent personal, individual, and/or group therapy; peer or leader-led group supervision; and training (12). With such exploration and support, therapists can metabolize their feelings of shame and humiliation.

Even if a therapist is highly motivated to form a group, the drawbacks, especially in a private practice setting, offer a formidable challenge. Multiple structural factors impede forming a group (e.g., lack of sufficient space, referral sources, reputation, confidence in group therapy among colleagues, institutional belief or support, or financial incentives in clinic settings) (13, 14). The desire to combat these barriers provides additional rationale for individual therapists to avail themselves of the sophisticated, state-of-the-art group training and certification programs and the wide professional networks offered by organizations such as the American Group Psychotherapy Association (AGPA) and its more than 30 local affiliates. Such organizations promote awareness that group therapy is a specialty (15), not simply an adjunctive therapy to serve more patients at one time or to help patients pass time while waiting to access individual therapy.

Still, many therapists feel untrained and are loathe to lead a group without having sufficient training or experience. Many are unaware that specialized training includes instruction in issues of diversity, equity, and systemic racism and inclusion, which are prominent societal foci (16) actively addressed by many national and international organizations, including the AGPA.

In addition, many therapists, even those with expertise in individual therapy, feel unknowledgeable, unskilled, and, in some instances, affectively dysregulated by the intensity of group therapy (17). To the degree that therapists enjoy the gratification of being the central helpful figure in a patient's life, it can be unsettling or depriving to have to share this position of prestige with others (18, 19). This notion of being pivotal in the life of a patient is intensified for therapists with a psychodynamic or psychoanalytic orientation, because these models often prize change occurring through exploration of the transference or through the presence of a corrective relational experience. These therapists may not realize that group therapy is ideally suited to accomplish these ends because of its multiple transferences and myriad relationship opportunities.

Therapists, as individuals, may themselves be subject to social anxiety or attachment-related fears of judgment, rejection, or attack when sitting in a group with people who arrive hurt by others and who feel momentarily relieved of this hurt when they aggress against others. In addition, therapists may fear having their own retaliatory aggression evoked in the group. Therefore, similar to the core issue that exists for patients, therapists may feel the powerful fear of being shamed or humiliated, unmasked in the eyes of many, not as a wizard, but as the person behind the curtain with a compelling voice but a lack of substance.

In individual therapy, and even couples therapy, fewer eyes are trained on the therapist, therefore reducing the chance that the therapist will be challenged and virtually eliminating the chance of a challenge occurring in public. With many young professionals, whether students, psychology or psychiatric residents, or colleagues, this public challenge, and even the implication of challenge from silent members, seems to create a core reluctance to train to conduct of group therapy. It is daunting, to say the least, to try to help a group of people who arrive with different needs, goals, and levels of attachment and emotional health, even if the therapist strives carefully to configure the group. Additional challenges that can arise from cultural and ethnic diversity (20, 21) also contribute to the formidable barriers to entry for the individual therapist.

Beginning a new therapy group is among the most difficult tasks for any therapist. Davidoff (22) has written that some therapists, perhaps especially those trained as medical doctors, may be

> particularly vulnerable to shame since they are self-selected for perfectionism when they choose to enter the profession. Moreover, the use of shaming as punishment for shortcomings and "moral errors" committed by medical students and trainees—such as lack of sufficient dedication, hard work, and a proper reverence for role obligations—probably contributes further to the extreme sensitivity of doctors to shaming.

As readers of this journal know, there are powerful transference and countertransference components at play when therapists face the experience of inadequacy or incompetence, let alone have it observed (23).

THE SHAME CENTRAL TO GROUP THERAPY

For the therapist, shame can come from ordinary situations. Consider this example offered by Gans (24):

> Many years ago, a group patient noticed a bandage on one of my fingers and asked me if I had hurt myself. I immediately answered, "Yes," but the answer was a lie. I have a habit of sometimes biting the skin around my fingernails, and the Band-Aid was to keep me from doing it more. Why did I have to be so embarrassed about one of my foibles that I had to lie about it during an enterprise that is based on honesty? Gradually, the following realization dawned on me: How could my group members ever bring their shameful secrets to a group run by a leader who needed to be so perfect?

All humans carry shameful secrets—feelings we have about ourselves (10). These feelings of shame and humiliation are not to be confused, necessarily, with feelings of guilt about having harmed another person, although the shameful feelings may contain those as well.

De France et al. (25) wrote, "Shame involves global, self-focused negative attributions based on the anticipated, imagined, or real negative evaluations of others and is accompanied by a powerful urge to hide, withdraw, or escape from the source of these evaluations." Many theorists have suggested an important distinction between guilt and shame, in that guilt often occurs privately and shame requires a public context. However, the research evidence does not support this distinction. Tangney et al. (26) analyzed autobiographical descriptions of events involving self-reports of guilt and shame and concluded,

> Although both shame and guilt were most often experienced when others were present, "solitary" shame and guilt experiences did occur with some regularity—and shame was just as likely as guilt to be experienced when alone. In other words, public exposure and disapproval did not appear to be special prerequisites for the feeling of shame.

As Deem and Ramsey (27) noted, "Rather than characterize shame and guilt as self-focused and action-focused, respectively, we suggest that it is more useful to conceive of shame as focused on the self qua object, and guilt on the self qua agent."

Potential group therapy participants clearly experience shame, as we all do, in the privacy of their homes or in their private lives. To enter a group with potential shamers present is extraordinarily undesirable. As Thomason (28) put it, "We feel shame when we fail to be the people that we hope or strive to be." Why would anyone want that failure to be exposed to others? Is there any benefit to such exposure? Proponents of group therapy answer with a definitive yes.

Consider this case example, in contrast to the anecdote featuring Damien above. Samantha, a mother of an 8-year-old boy, had been a member of her group for 1 year. It was nearing Christmas, and group members were sharing their delight at watching little children anticipate the gifts that would come. Samantha, however, expressed anger at her son, describing her fear that he was becoming a selfish child. Group members tried to normalize her anger and fear and to reassure her that he was just a boy. Samantha began to cry.

> You don't understand. Ever since he was born, I felt there was something wrong with him. Actually, something wrong with me. He wasn't gaining weight once he got home, and then he cried for the first 5 months. I didn't know how to console him, and I was depressed. I felt like a failure.

She trailed off. With encouragement, Samantha continued, "I've never said this to anyone, but there were moments when I wanted him not to live. I just wanted him to be gone." With deep shame, she wept uncontrollably.

When she calmed, the group responded, as groups often do, with acknowledgment of the archetypal universality of such feelings. The group members provided tearful memories of their own such feelings, including resonant memories of themselves wishing that a child or loved one who was the cause of profound distress were gone. Samantha left the group experiencing enormous relief in the recognition that even after revealing such unspeakable feelings, she remained accepted and admired by her peers.

In this example, the power of the group experience to encourage the expression of shameful experiences—to hold that shame in a shared space with others who recognize the experience personally and can therefore help each other to process, metabolize, and integrate the shameful experiences—is an antidote to shame (29). In group therapy, peers serve as "agents of change" (30). This antidote is not present in nearly the same measure in individual therapy, because the context for the overt expression and ownership of similar experiences is vastly different. The individual therapist does not typically share personal experiences of feeling shamed in empathic identification with the patient, even as those experiences surely exist.

THE SHAME FELT BY THE GROUP THERAPIST

As Dies (31) has written,

> Beginning group therapists are confronted with an extraordinary challenge when they approach their first group experience. They must lead their initial treatment group without knowing where they are going or how to get there! There is no shortage of theoretical prescriptions for how to conduct group therapy, but it is difficult for the novice and even the seasoned practitioner to sort through the various models to establish a coherent framework for therapeutic change.

It does take courage (32).

However, because there are dozens of approaches to group therapy (33), therapists interested in pursuing training can elect an approach that is consonant with their prior training or current preference, one that is less likely to result in challenges to their competence. Although the obstacles for individual therapists to add group therapy as a modality are not insignificant, neither are they insurmountable. With the core anchors of their own personal, individual, and group therapy, and some form of group supervision, these obstacles can be addressed and overcome.

Moreover, it is precisely the individual therapist's own fears of exposure to shame and humiliation that can contribute to his or her effectiveness in leading groups. With proper professional support and training, therapists can use their life experience, self-awareness, and countertransference to deeply attune to and resonate with group members' vulnerability to shame and to overtly recognize the bravery of members who take relational risks in the group.

Perhaps this article, in concert with the other pieces in this special issue, can encourage individual therapists to deem group therapy a valuable clinical modality for the patients in their practices. As Gerald (34) asserts, "[Leonard] Cohen wrote that there's a crack in everything and that's how the light gets in. The cracks in human connections may be the best opportunities for the greatest growth to occur." Furthermore, according to Judith Herman in her groundbreaking work on trauma and recovery, "The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience" (35).

As I have implied throughout this article and now state directly, the rewards for the group therapist are enormous and well worth the anxiety of feeling inadequate in the public group sphere. Shay and Motherwell (36) expressed it this way:

> For us, working with people who begin as strangers and who become intimate partners in learning about themselves and others is compelling, challenging, and often extremely moving. As leaders, we feel affectively engaged, and intellectually and emotionally stirred by our patients' courage, perseverance, and willingness to risk. This encourages us to risk the possibility of exposure and the possibility of self-knowledge and growth. To engage with others in such a difficult but rewarding process gives us hope and reinforces what we know about community and intimacy: that it is through respectful and positive attachments [that] we become more resilient, empathic, and sympathetic to the pain and needs of the other.

For many group therapists, there are few experiences as gratifying as observing real changes in real individuals in real time.

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The author has confirmed that details of these cases have been disguised to protect the privacy of the patients described.

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