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# Case report: Failure of Group Therapy with Elderly Russian-Jewish Immigrants (An Exploratory Analysis)

Gennady Berezkin, M.D.

## Abstract

*This paper is a description of an unsuccessful attempt to carry out group therapy with elderly Russian-Jewish immigrants.*

*An attempt was made to conduct group therapy following general principals of traditional psychotherapy with geriatric populations.*

*In the final analysis, we conclude that culturally based preconceptions toward psychotherapy, culturally based stereotypes of interpersonal relationships and culturally-based transference to the therapist were the primary reasons for the development of negative transference and resistance which culminated in the ultimate failure of group psychotherapy with this group of elderly immigrants.*

## INTRODUCTION

For elderly patients, group therapy is a particularly effective therapeutic modality, as it can provide a forum to explore problems of social isolation, feelings of inadequacy, anonymity and losses through comradeship, emotional self-expression personal feedback and exploration of cognitive alternatives (1,2). Tross and Blum described the typical progression of the group therapy process for elderly patients as establishing boundary behaviors (3), followed by subgrouping, organization behaviors, establishing personal significance, self-disclosure, expression of conflict behaviors, group to leader and leader to group interactions, and establishing group tone (4).

It could be argued that the elderly have a greater need for psychotherapy compared to other groups, as they more frequently have sustained losses or reduction of resources or a decline in independent capacity due to mental or physical disability (5).

Since the focus of group therapy with geriatric patients is often a preoccupation with themes from their past, the elderly need attention that is focused thoughtfully on their particular life circumstance and their particular dilemmas (6).

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In our outpatient geriatric clinic we have several Russian-Jewish elderly immigrants with depression and adjustment difficulties. These patients were not able to participate in the usual group psychotherapy because of the language barrier. We decided to organize group psychotherapy in attempt to help patients with acculturation issues (social and cultural adaptation), to improve patient's social and interpersonal skills and to explore problems of social isolation, feelings of inadequacy, anonymity and losses. The group therapy would be conducted by the author who is Russian-speaking psychiatry resident, and also an immigrant.

## METHODS

A supportive group therapy was chosen as an initial model with a plan for 8–12 weekly one-hour sessions. None of the potential candidates had any previous exposure to psychotherapy. The primary goal was to establish an alliance with the patients and to explore the patient's problems through discussions about their past and current experiences. The plan was to encourage subjects to share their feelings and concerns about interpersonal interactions, especially within their families. To facilitate patient interaction, tea/cookies were offered during breaks within the sessions.

We expected that early sessions would focus on the participants' perceptions of the situation in Russia, preimmigration and immigration experiences and evolve into discussions of the patients problems as outlined by common themes such as continuity with the past, understanding the modern world, independence, etc. (7).

Initial invitations to join the group were made by telephone and by mail. All written and verbal information was presented in Russian and it was made clear that group would be conducted in Russian also. All of the patients received descriptions and explanations about the treatment in writing as well as verbally. Face-to-face preliminary discussions about the group were optional but all patients preferred to use printed and verbal (phone) information instead of making a visit to the clinic. The issues of group confidentiality including outside group disclosure had been discussed.

## DESCRIPTION OF PATIENTS

All patients but except those with dementia, psychotic disorder and severe medical debilitation were included. Initially, 11 patients were eligible for participation in the group. All patients who were selected met DSM IV criterion for Mood and/or Anxiety Disorder. Ages ranged from 60 to 80 years. All patients lived a short distance away from the clinic. Four patients categorically refused to participate in the sessions indicating various reasons, including involvement in other treatments, "feeling too sick" or "unspecified reasons."

The seven patients agreed to come in and we decided to start the group. All of them were women; Russian was the native language for all of them. All of the patients immigrated from the urban centers of Russia, Ukraine and Belarus approximately 1–5 years before this therapy, except one patient who lived in the USA for more than 10 years. All patients were ambulatory. The most common diagnoses were Major

Depression or Depressive Disorder NOS (4 patients), followed by Major Depression with Generalized Anxiety Disorder (2 patients) and Bipolar Disorder (1 patient). The psychiatric symptoms were in full or partial remission at least two months. For all participants who had cardiac problems, other medical problems included migraine (1 patient), asthma (1 patient) and hypothyroidism (1 patient). All but one patient lived in the same area in the range of 10 miles from the outpatient clinic. All patients required transportation to come to the clinic.

All patients spoke very little English or no English at all. Most of them lived separately from their children but in the same neighborhood. Most of the participants were home bound with their usual everyday activities consisting of interactions with their families, shopping in the nearby supermarket or in Russian food stores or attending activities at the Jewish Community Center where they could sometimes use Yiddish to communicate.

## RESULTS

After lengthy phone discussions seven patients agreed to come for the first session, however, the first session was attended by only 4 of the 7 patients. Our expectations were that at least 7 patients will start the therapy and the 3 selected participants who didn't come in for the first session will come in later.

The group began with self introductions. All members spoke their names, age, marital and family situations, along with educational and professional backgrounds. Group members appeared to be relaxed and talked about their previous jobs, previous achievements and previous social status. The conversation was calm and was concentrated more on "success" stories than on life difficulties or tragedies. They became more cautious when the subject of discussion turned to their experience with American Life. A noticeable shift occurred and members became formal and superficial, they seemed reluctant to become further involved in this discussion and appeared to keep a greater distance from each other. Two patients eventually dominated the discussion by talking about how bad their past was compared to their present situation. They talked about how the local Jewish community and local immigration officials were extremely nice, helpful and supportive.

As silences grew more uncomfortable, the group needed to be facilitated more directly, usually in a form of a direct question-answer type dialogue between the therapist and the patient. To induce discussion about motives for emigration, the therapist offered a hypothetical scenario about a woman who did not want to immigrate with her children because she did not want to lose her independence. The group split in their opinions: the two patients who dominated in previous conversations, had a negative reaction. They thought that she should move with the family (children) because otherwise she would lose family support and would have to face different life stresses on her own. The other two supported her decision to stay because they supported her freedom of choice and agreed that her dependence on her children would significantly increase if she immigrated. In the end, we summarized the discussions, the patients indicated that the group was "helpful" and that they

would consider coming again. We discussed the desirability of continuing the therapy and of possible future themes.

On the second session only two patients appeared. The other two called and explained they could not come because of the transportation or health problems. The participating patients did not offer any of their own subject matter for discussion. Again the therapist suggested they might discuss their preimmigration expectations. Both patients made the decision to immigrate because of their family's choosing. They both preferred to stay at home (in Russia) and to maintain their usual style of living, but the fear of separation from their family (children) was the biggest reason to immigrate. They did not expect an "easy life" in US. On the contrary, they knew that life would be a struggle because of a cultural and linguistic isolation, economic dependence, and financial instability. They discussed how their adaptation to a new way of life was difficult, especially the language and the communications barrier. Gradually, they developed their positive and/or negative feelings toward the "new world." One patient described a situation which made her very angry. She was in a bus, where teenagers had occupied all of the seats and she (with the other elderly passengers) had to stand and nobody offered a seat to them. She stated that it would never had happened in Russia. The other patient described how a volunteer's family helped her after arrival in the USA. She was very surprised that people who did not know her had so much interest and enthusiasm for helping her.

The third session was attended only by 2 patients, who did not participate in the previous session. They did not want to elaborate on the reasons why they did not come to previous session other than the explanations they gave before on the phone. The 2 patients who did not show up did not call either. Upon calling them later they gave explanations of health problems ("they did not feel very well"). The subject of discussion this 3rd session was on "old times." They discussed their childhood and adult experience from 1930-s, 40-s, 50-s and 60-s. Most significant were their emotional memories about W.W.II, post war time and Stalin's death. Both of them went through the communistic propaganda machine (kindergarten, school, college), but neither they nor their family experienced any direct impact of Stalin's repression. They came from different social circles: one was a secretary with a low wage from a provincial southern town; another belonged to cultural elite—educated and economically secured. They recalled that the "old times" were harsher but "higher in morals." Both patients avoided political discussions and showed resistance to talk about any personal experiences of political nature.

On the 4th session nobody showed up. Everybody was telephoned and quite similar explanations were received, such as:

- they don't want to be "open" in the presence of people from the same community,
- they were afraid that their sharing could be turned against them,
- they were not used to talking about their personal feelings in public, etc.

Attempts were made to explain to them that the sharing of personal experience was supposed to help them handle their current stresses and problems. Confidential-

ity was stressed but it was acknowledged that no guarantees could be made that group participants would not discuss the group issues outside the group. These issues were so important for each member that that all participants decided not to return.

## DISCUSSION

The following discussion will attempt to explore possible reasons for the group failure and in a large view, to explore what factors may be important to know in working with future immigrant groups.

Initially, the idea to organize group therapy with Russian immigrants was based on the assumption that this group is more isolated and more predisposed to different stresses, especially the stresses which related to the immigration adaptation process. We could not include these patients in the regular groups with traditional therapy because of the language barrier and socio-cultural differences (8). We assumed that the therapist with the same "mother tongue" and cultural background have the advantage of allowing us to avoid a possible cross-cultural bias. Casimir and Morrison noticed that therapists may be biased by seeing normalcy and deviance through the cultural lens of the dominant group in society and may confuse cultural misconceptions with personal misinterpretations (9).

Our group was predictably homogenous. We selected candidates by language, age, culture and medical and psychiatric stability. All candidates were female. Therapy with homogenous groups would be expected to progress more quickly especially by using a focused approach on a short-term basis (10). The therapist's goals included: 1) improving interpersonal relationships through the increased self-awareness and group feedback, 2) enhancing self-perception and attitude and 3) symptom relief through a focus on better coping strategies for chronic medical problems (11).

Our preparation was congruent with the Preparation Grid (the list of certain issues that needs to be discussed with every patient in the process of preparations for group therapy such as the patient's role in the group; place, time and duration of the sessions; rationale for the group, and also attendance rules) (12). Our pretraining was limited to just telephone contacts with descriptions and explanations of the planned therapy. This method appeared to provide the sufficient information for the patients to make a decision to start the therapy. The printed and video information such as "Psychological Mindness" (13) was unavailable in Russian.

Early on in the therapy, our patients developed the resistance and negative transference to the group process that could be attributed to multiple factors.

Perhaps it could be a connection between the negative transference and "therapeutic pessimism" of elders (14). McGee and Lakin found that the aged person is often less receptive than younger and middle age persons to "verbal" therapy, especially to group therapy where participants have to share and exchange with others (15). In this group the members seemed to prefer direct dialog with the therapist over dialog between group members, what Konig and Linder identified as a resistance to the group situation (16). Negative transference in elders had been

described by Davis and Klopfer as being related to their struggle to maintain power in their competition with care givers, family, and peers (17).

In our group, the participants fixated on their past experiences ("living in the past"), and on issues that did not relate to their current life situation ("outside lives"), with themes that Louis Ormont connected to the development of Group resistance (18).

Even during the initial steps of the preparation, potential participants showed low motivation, fear and poor understanding of how talking to the others (people inside the group), in whom our patients ultimately revealed that they had no trust, would help them to solve their internal problems. Most of our patients perceived the therapy as entertainment or as a part of some mandatory procedure. Nobody had previous exposure to group therapy or any other types of psychotherapy.

Collectively, the immigration process has been described as a transition from "ghettoization" into acculturation that often takes several generations to achieve (19). Our patients were still largely living in a "ghetto," given the significant isolation and dependence on their family and to outside authority figures and they often felt that they had very little decision making power. Markowitz described Soviet Jews as attempting to distinguish themselves from others in the Soviet Union by drawing boundaries around themselves in America, as they often are feeling rejected by other groups (20). For these reasons, perhaps, the therapist was identified as an authority figure, who had power to push them to be a part of the "procedure." The sense of "Awareness, Freedom and Responsibility" that we tried to create in the group process and was described by Page and Berkow (21) gave the patients a better sense of power that allowed them to ultimately skip the sessions and finally to stop the therapy.

Flaherty, Kohn and others described the difference between Soviet-Jewish immigrants and other immigrants in the USA as a situation where returning to the homeland ("always returning home syndrome") is unrealistic (22). For elders, the return to their homeland became even more unrealistic. We expected that this situation made them more vulnerable to psychological problems but perhaps more open to psychological treatment. Kohn, Flaherty and Levav used the term "psychophobia" in their observations of Soviet-Jewish immigrants that showed a strong tendency to avoid considering their problems as psychological and preferred to view them as biological or physiological (23). Chertok explained this as a part of the ideological phenomena of the Soviet Era (24).

"Psychophobia" usually led to the somatization of symptoms, lack of insight and externalization; what Goldstein described in Soviet immigrants as "Homo Sovieticus" (25). He found that his attempt to clarify patient's issues ended in the patient's distrust and hostility toward him. Goldstein interpreted the occurrence of this phenomenon as a patient's search for a neurological or a physical solution for psychological problems and because "the whole notion of exposing one's own personal feelings to a stranger, expressing oneself in a contractual relationship, and paying money for "just talking" is deeply foreign to the Soviet spirit" (25).

"Psychophobia" is only one possible explanation of the reason for this failed attempt of group therapy. The differences in lifestyle and social structure, which our

patients brought with them, had a significant impact on the development of the resistance and negative transference. These cultural differences were clearly demonstrated in Horovitz's study by using the Roter's I-E scale, the results showed clear differences between North American immigrants who represent American (Western) cultural-social values and immigrants from the Soviet Union in Israel who are from the same cultural-social group as a Soviet immigrants in US. The Soviet immigrants had different concepts of friendship which friends were "confined to a very small circle of personal friends with whom people developed strong family like personal ties, while a broader circle of people, with whom the individual has contacts, is perceived as consisting of either indifferent or even hostile individuals" (26).

The therapist in this group attempt is an immigrant himself. Kitron found that the immigrant therapist who speaks the "mother tongue" compared to a "local" therapist, who also speaks the "mother tongue," can be a reason for negative transference because the immigrant therapist cannot symbolize the "desired sense of strength." Kitron described a common negative attitude toward the immigrant therapist who is as equally weak as other immigrants, having endured similar immigration experiences, in contrast, local therapists symbolized or idealized a sense of strength and power (27).

Another possible reason for a negative outcome might have been an inexperienced therapist. Aurbach and Johnson (28) positively correlated level of therapist's experience to better results of the therapy with some exceptions. But more recent data is contradicting: Lambert and Bergin (29), in their review of multiple studies, couldn't find any significant differences in professional versus nonprofessional therapists. They demonstrate trend for experienced therapists to be superior to inexperienced ones, but at the same time they concluded that the most effective therapists were those who were currently undergoing training or had just completed it. They also indicated that a therapist's empathy could be the most predictive factor of being an effective or ineffective therapist.

## SUMMARY

Despite our discouraging experience in the organization and conduction of group therapy for elderly Russian-Jewish patients, we still believe that group therapy for this group of population is possible.

In retrospect, this attempt may have failed in part due to inexperience of resident therapist but also because this group was predisposed to:

- 1) develop resistance based on different cultural perception of group process,
- 2) develop culturally based misinterpretations of goals and principles of group therapy and psychotherapy in general,
- 3) develop negative transference toward the therapist as result of misidentification of his role in group,
- 4) have age-based biases limiting group process.

We propose that the outcome might be better if the group therapy is conducted



in a geographically convenient location inside the community and the therapist is using "mother tongue" but is not also seen as culturally biased. Therapy should be based initially on supportive or "recreational" principals or perhaps as part of an "adaptation procedure" used by Immigration or Jewish support organizations in attempt to prevent depression and other immigration related psychopathology in Russian-Jewish immigrants.

#### APPENDIX

Before final submission of the article the consent for release of information and the permission for publication had been obtained from former participants.

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