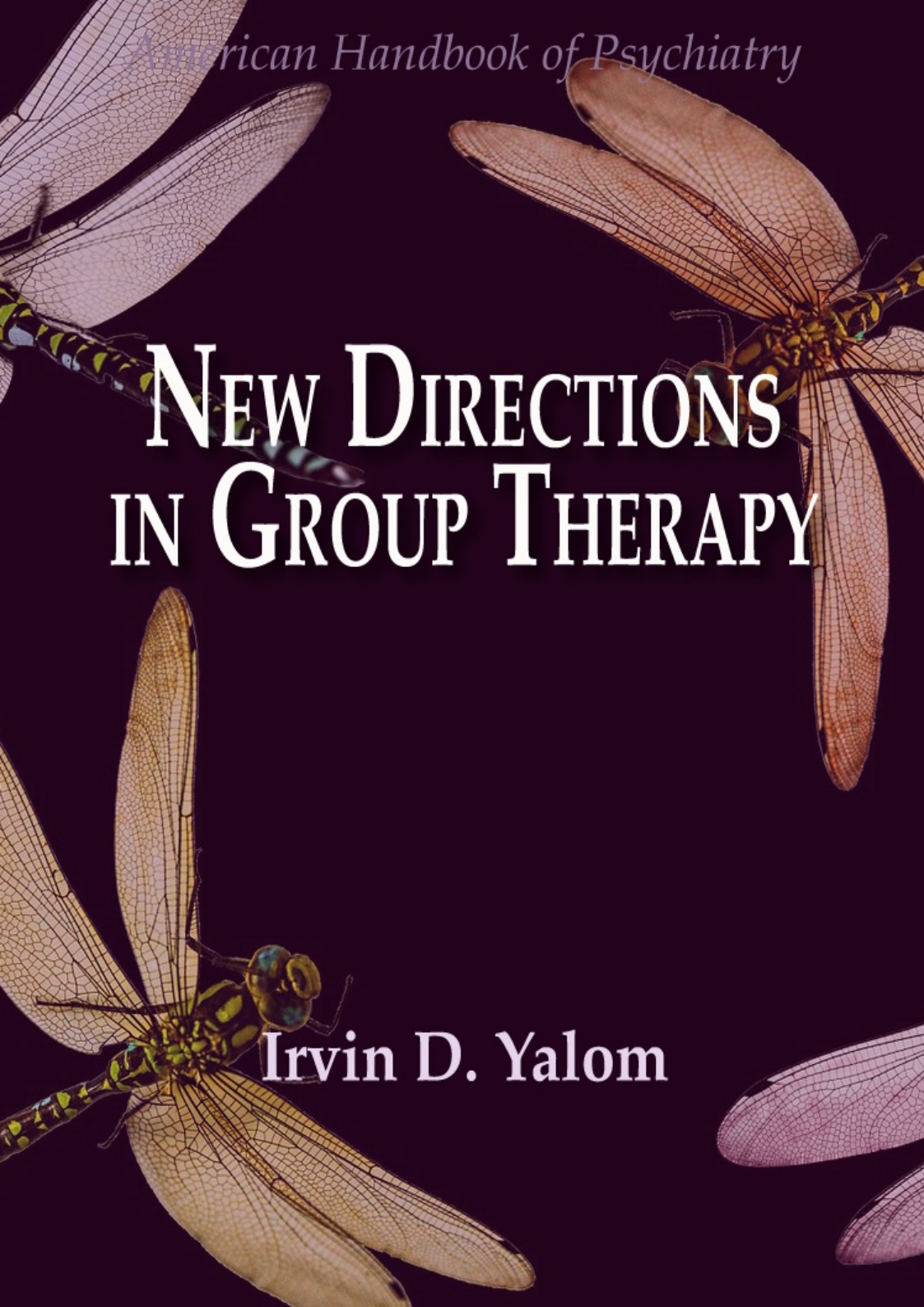
New Directions in Group Therapy



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NEW DIRECTIONS IN GROUP THERAPY

What of the future of group therapy? Group psychotherapists at the meetings of national professional associations may choose from an arresting display of training opportunities. A sprinkling of workshop titles will provide us with the flavor of current directions: Marathon Group Therapy, Integrating Encounter and Gestalt Techniques into Analytic Group Therapy, Body-movement in Group Therapy, Multifamily Group Therapy, Marital Group Therapy, Video-tape Playback Group Therapy, Transactional Analysis and Contract Psychotherapy in Groups, Nude Marathon Group Therapy, Psychodrama in Groups, Non-verbal, Gestalt, and Encounter Games in Group Therapy.

If each of these approaches represents a substantial new trend, then there is scarcely any keeping abreast of the group-therapy field, much less in foreseeing future directions. It is my opinion, however, that these new developments do not constitute a coherent intellectual thrust; rather than prefigure the future they resemble more the aimless whirlings of a broken mechanical toy, more a flamboyant proliferation than a Renaissance. If this is true, then an interesting question arises: why has the youthful and robust group-therapy movement passed so quickly into a high-baroque phase? This chapter will address itself to this question and will then attempt to describe those foundations of group therapy which are likely to survive and shape the

substance, if not the form, of the field of the future.

The Baroque Period in Group Therapy: Evolution and Explanation

We gain better perspective of the field by examining the rather brief history of the evolution of group psychotherapy. Although for centuries the group has intuitively been used for support and succor of troubled individuals, the first explicit systematic attempts to harness the potential power of the small group for psychotherapeutic purposes occurred in the 1920s and 1930s. The technique was wrenched untimely from its adolescence by the advent of World War II. Group therapy's growth spurt was driven by an economic piston: the large number of military psychiatric patients and the small number of trained psychotherapists urged an immediate and widespread use of groups as a psychotherapeutic method. In the following years there was considerable attention paid to the application of small groups for different types of patients and in different clinical settings: groups were used in inpatient and outpatient clinics, in day hospitals, in prisons, in schools, in family service agencies, in psychoanalysts' private offices as well as on the back wards of state hospitals. Theoreticians—Freudian, Sullivanian, Horneyan, Rogerian—explored the application of their conceptual framework to the theory and practice of group therapy. The differences between the different approaches to group therapy thus paralleled the differences between the theoretical schools from which they

sprang.

A major shift in the practice of group therapy occurred in the mid-1960s when the group-therapy tradition collided with a related but parallel and separate stream—the encounter-group movement.

"Encounter group" is a rough generic term under which may be classified a large number of group approaches. Examples may be gleaned from university bulletin boards, growth centers such as Esalen, free university catalogues, and mountains of second-class mail pamphlets. We know them by such names as t-groups, NTL groups, human-relations groups, human-potential groups, and personal-growth groups. Despite the colorful and varied nomenclature, these groups share several features. They are generally small enough (six to twenty members) to permit considerable face-to-face interaction; they focus on the here-and-now (e.g., the behavior of the members as it unfolds in the group); they encourage openness, honesty, interpersonal confrontation, and self-disclosure; they encourage strong emotional expression; the participants are not usually labeled "patients," the experience is not ordinarily labeled "therapy"; the groups do strive, however, to increase awareness and to change behavior. The explicit goals of the groups may vary, and although occasionally they seek only to entertain, to "turn on," to provide joy, they generally strive toward some type of personal change—change of behavior, of attitudes, of values, or of life style.

The current term for these groups is encounter group. The older, superannuated term is "human-relations-training group (t-group)." The transition from one label to the other represents symbolically the evolution of the trend which some have referred to as the encounter group social movement.

The prototype of the present-day encounter group took place in 1946 when a group of social psychologists and educators first realized that an experimental group experience was a powerful way of teaching human relations. Members of the groups were helped to acquire interpersonal skills in the basic human-relations training group (which was later shortened to t-group, the "t" for training) or sensitivity group (for training in interpersonal sensitivity). A large organization—the National Training Laboratories—evolved, which sponsored large numbers of training groups for individuals to undergo a personal learning experience. T-group leaders described concepts such as "feedback" (the giving and receiving of interpersonal perceptions), the observer-participant role (studying that process of which one is a member) and designed some highly imaginative group techniques or exercises to accelerate development or explicate the dynamics of the group. Industrial organizations soon learned that it was good to have individuals in key personnel positions who had highly developed interpersonal abilities. Indeed, industry also discovered that large-scale organizational problems could be reduced through a group approach. For example, a unit with low

morale, low productivity, high absenteeism, and personal turnover could be helped by holding a laboratory in which the entire unit could meet together in a group in order to work through the interpersonal friction so often underlying organizational conflict. A number of other institutions, for example, departments of education, organized religion, as well as agencies of local and federal government, began to utilize the experimental small group as a basic mode of lubricating organizational development.

The modern, swinging, let-it-all-hang-out encounter group appeared as a speck on the horizon early in the 1960s and derived from many sources. One important development occurred when several West Coast group leaders boldly questioned the concept of "education." Till then the goal of human-relations education had been the acquisition of interpersonal and leadership skills. Some leaders proposed a broader and humanistically based redefinition of education. Education, they argued, was synonymous with personal growth; the true educator helps each student discover and mine his hidden untapped resources. The emphasis thus shifted from technical education—from learning about group dynamics —to self-discovery and to the development of one's full potential. The groups were renamed personal-growth groups and later by Carl Rogers, the "basic encounter group."

I do not mean to imply that the encounter group has a single source, for the evolution from the human-relations training group to the personal growth

or encounter group is as much manifestation as cause. California in the 1960s provided fertile soil for the cultivation of any experience that promised intimacy and a sense of community. For nowhere else had there been a more inexorable deconstitution of traditional, stabilizing, intimacy-sponsoring institutions. The extended as well as the nuclear family, the stable neighborhood or work group, the local merchants, the home-visiting general practioner, the neighborhood church —all had fallen prey to the demands of progress and a runaway technocracy. The small group thus masqueraded as a well of intimacy: one small oasis where people could drop the facades demanded by a fast-moving, competitive society and confront themselves and others with all the fears and doubts of the basic human condition.

The "third force" in psychology that emphasized a holistic humanistic concept of the person provided impetus for the personal-growth group from yet another direction. Psychologists such as Abraham Maslow eloquently argued for the need of a "liberating model" in addition to or instead of a teaching or a therapy model. Other derivative streams arose simultaneously but independently from the same soil: Synanon, gestalt therapy, the marathon, alternative life-style systems. They suggested that we are all patients. The disease is an uncontrolled, dehumanizing, technocratic culture, the remedy is a return to grappling with basic problems of the human condition, the vehicle of the treatment is ideally the small group that becomes "group therapy for normals." The differentiation between mental illness and

health grew as vague as the distinction between treatment and education. Personal-growth group leaders claimed at the same time that patienthood is ubiquitous and that one need not be sick to get better.

The inevitable confluence or, as some would have it, collision between the two fields is by now readily apparent to the reader. With personal-growth group techniques purporting to offer group therapy for normals and with the "patienthood" label becoming ever increasingly relativistic, considerable confusion ensued.

Although in its first decade the t-group was generally led by an educator or social psychologist, recent years have seen the influx of an increasing number of clinicians into the field. Many psychotherapists were participants in t-groups and subsequently became t-group leaders, using these techniques in groups in their consultation work and in their teaching. Many have been impressed with the apparent potency of a number of t-group techniques and have applied these in their psychotherapeutic work. (We shall discuss some of these techniques in detail later in this chapter.)

A reciprocal development has occurred amongst encounter-group leaders who have had no specific clinical training, but whose experience has suggested to them that members of their group had therapeutic experiences and that, in fact, there was no difference between the psychotherapy group

and the encounter group. Accordingly, many growth centers either intentionally or unwittingly advertised their groups in such a manner as to attract individuals with rather significant emotional problems, whose hopes for immediate, near-miraculous relief were augmented by an encounter-group mystique suggesting that it could condense months, even years, of psychotherapeutic work into a single, prolonged, intensive group experience. Many psychotherapists reacted vigorously to this development, not only because of such substantive issues as the incumbent risk and the ethical breech in offering more than could be delivered but also in fear of an invasion of their professional territorial rights. Indeed, in some sections of the country, the encounter-group network has served as an auxiliary mental-health system. One suspects that a very significant number of troubled individuals enter some type of small personal-growth group who, only a few years ago, would have applied for help from a traditional mental-health resource.

Of course, scurrying in between these tumbling pillars was the confused would-be patient, who was faced, on the one hand, with the mass-media promulgation of the effectiveness of encounter groups, and, on the other hand, with the medical professions warnings of high risks, but, nevertheless, themselves offering a profusion of varying group formats, many of which were indistinguishable from encounter-group approaches.

Some relevant research may rescue us from this quagmire of claims and

counterclaims. My colleagues and I reported in 19723 the results of a large-scale research project that studied the process and outcome of encounter groups. The overall study is reported in detail elsewhere, but I shall describe some of the findings that are relevant to this discussion. We studied the leader behavior, the group process, and the short and long-term outcome of eighteen encounter groups representing ten different ideological schools: gestalt therapy, transactional analysis, t-groups (traditional human-relations or sensitivity groups), personal-growth groups (West Coast version of human-relations groups with the emphasis on intrapersonal growth rather than on primarily interpersonal and group-dynamic learning), Synanon, psychoanalytically oriented encounter groups, marathon groups led basically in a Rogerian style, psychodrama groups, sensory awareness (Esalen groups) and encounter tape groups (these groups had no formal leader except for a tape recorder that each meeting provided the members with procedural instructions).

The leaders were all highly seasoned professionals, all had many years of experience in the field, and many had national reputations. The subjects were Stanford University undergraduate students between the ages of eighteen and twenty-two. Each group lasted a total of thirty hours, some in a massed format with two or three time-extended (marathon) meetings. Others had shorter meetings, spaced approximately one week apart. Leader behavior was studied by trained observers who coded all their behavior during the

groups, by questionnaires filled out by participants, and by transcripts of the meetings in which leader-verbatim comments were recorded. Outcome of the groups was measured by a massive battery of outcome instruments, including self-administered questionnaires, evaluations by friends and members of their social network, ratings by other group members, ratings by the leader, and from a number of other perspectives such as school performance, life decisions, etc.

Let us turn to several aspects of the results that are relevant. The research indicated that the encounter groups studied were all in all (comparing all the encounter-group participants with a large control population) ineffective change agents. When compared, for example, with well-designed outcome psychotherapy studies, the encounter groups produced far less positive change and more negative change ("casualties") than traditional therapy. We recognize that comparisons of this sort are risky —the participants of these groups did not enter as patients. The outcome measures were similar but not entirely comparable to psychotherapy outcome measures. The psychotherapy studies used as comparisons are individual psychotherapy studies, not group psychotherapy studies (there are no rigorous outcome studies on group psychotherapy). Nevertheless, despite these qualifications, there was convincing evidence to prove that, regardless of the criterion used, the encounter groups were nonproductive agents of change.

We do not suggest that, by other criteria, the groups were not "successful." The overwhelming majority of the participants liked the groups. They found the experience exciting, interesting, and often compelling. The groups were potent in that they aroused strong emotions and, for a small minority of individuals, they were successful in contributing to a very pronounced and very positive shift on a number of important outcome dimensions.

Another finding was that the ideological school to which leaders belonged told us little about the actual behavior of the leader in the group. We found that the behavior of the leader from one school—for example, transactional analysis—resembled that of another leader from the same school no more than it resembled the behavior of any of the other seventeen leaders. This finding was a general one. It leads to the rather obvious conclusion that one can know what a group leader does only by observing his behavior, which is not predictable from what he says, he does, or from his membership in a particular ideological school.

Although, in general, the members of the encounter groups did not experience significant positive change, there were, nonetheless, some very striking differences in outcome among the eighteen groups. Some groups were so ineffective that none of the participants experienced positive change and several experienced some type of negative result; other groups were so

effective that the great majority of individuals experienced positive results and no members underwent any negative change. From the foregoing it is clear that the effectiveness of the leader is not a function of his ideological school but is very much a function of his behavior in the group. We constructed a new leader typology based on actual leader behavior and were able to demonstrate that certain leader "types" were highly correlated with certain outcome patterns. The "provider" (the leader who provides both high-positive support and a considerable cognitive framework) for example, is likely to lead a high-yield, low-risk group, while the "energizer" (the leader who is highly charismatic, both highly supportive and attacking, very active, and very personally revealing) is likely to lead a high-risk and a moderate-to-low-yield group.

A study of the actual process of change in the participants was singularly illuminating. In brief, the research revealed that change does not revolve around the solitary sun of the leader; the data provided strong evidence that psychosocial relations in the group played an exceedingly important role in the process of change. For example, individuals in a role that included high influence, activity, and high-value congruence tended to have high-positive outcome, whereas members with low scores on this role tended to have low or casualty outcome. Members with little attraction to the group rarely finished with a positive outcome. Members who misperceived group norms or who were considered deviant by other members were quite likely

to have had a negative-learning experience. In short, there were many factors, powerfully influencing the change process, that occurred in the substratum of the group outside of the leader's level of awareness.

The vast majority of the encounter-group leaders attributed far too much importance to their direct contribution, to their immediate effect on each of the members of the group. They placed paramount importance on their personal ability to offer members insight, to confront, to stimulate, to challenge, to help members become aware of their feelings, to help members reveal themselves, to help them become "in touch with" their body. We found, however, that the effective leader intuitively augments the psychosocial forces at work. He helps to create a group that is a potent agent of change and an atmosphere within that group which encourages the type of support, trust, and acceptance so necessary to the change process. We say that the leader "intuitively" performs these tasks. By and large, he is unaware of the importance of these indirect functions. Most leaders fashion their style and their theory of change on their own personal observations of their groups. Given the invisibility (without some type of systematic inquiry) of these indirect factors, it is not surprising that they have not been appreciated in most leadership approaches. The research suggests, therefore, that some leaders may be exceedingly competent but have no accurate appreciation of the factors responsible for their success.

At this point we have come full circle to the query that launched this discussion: *why has the group-therapy movement passed so quickly into a high-baroque phase?* Part of the answer lies precisely in the fact that so many effective leaders are unaware of the reasons for their effectiveness. The sequence of events is often that the leader, through varied and often haphazard feedback mechanisms, grows convinced of his effectiveness. He then commences to transmit his skills to students, but passes on those techniques which he consciously conceptualizes and fails to transmit his intuitive, unconscious appreciation and utilization of many of the potent psychosocial forces that are of such fundamental importance. Too often he transmits only epiphenomenal behavior—behavioral characteristics that are idiosyncratic and largely irrelevant to his effective outcome. Consider one specific illustration. In the research described above, many of the leaders were deeply convinced of the efficacy of the "hot-seat" approach. This methodology consists of focusing the entire energy of the group on one person, who may literally sit in a designed chair for long periods of time. It was striking, however, to note that the results indicated that the use of the hot-seat technique was totally uncorrelated to positive outcome. Some of the most effective leaders and some of the least effective leaders were heavily committed to its use. The identical point can be made about a number of other highly prized leadership techniques, like the emphasis on extremely intensive expression of emotions, high self-disclosure, marathon meetings or

specific theoretical constructs such as gestalt therapy or transactional analysis. (It was striking to note, for example, that one of the most successful leaders and one of the least successful leaders were gestalt therapists.)

The problem is compounded even further by the difficulties inherent in assessing outcome. Group leaders may be exceedingly poor judges of their success or failure. (Our research demonstrated that the group leaders were particularly ineffective in noting which members had a negative experience.) Two major reasons for the leaders' poor evaluative marksmanship are selective inattention and efficacy-potency confusion. Time pressures and attention to the group as a whole often do not permit the group leader to collect the necessary information to make accurate judgments of the progress of each of his group members. Furthermore, there is a widespread tendency on the part of group leaders as well as group members to mistake potency for efficacy. Only rarely does it occur that a small experiential group does not provide a moving, emotionally "potent" experience for the participants. Groups mobilize a wide array of powerful feelings such as closeness, competition, rivalry, trust, dependency, and anger. The arousal of strong affects seems to be a necessary prerequisite, but it is not synonymous with change. We undergo strong emotional experiences all our lives without personal change ensuing. The relevant point, however, is that it is not difficult for ineffective leaders to mistake other attributes of their group for success, and once convinced of their competence they will accordingly attempt to

transmit *their* techniques to their students.

Thus, the field has many therapists, most of whom are unaware of the reasons for their effectiveness and some of whom are erroneously convinced of their effectiveness. These phenomena occur against a horizon of general dissatisfaction with therapeutic outcome: all the therapy approaches appear relatively ineffective or, more charitably, so equally effective that no single method can prove its substantially superior results.

The next developmental step is the establishment of ideological systems and training centers. Leaders who found systems and training centers are powered by complex motivations: an estimable sense of responsibility to teach others a method of treatment in which they deeply believe, or such personal factors as a search for glory, symbolic immortality, or the adulation of students to atone for too little or too tardy gratification from patients or colleagues.

The ideological schools do not usually suffer from a lack of disciples. Just as nature abhors a material vacuum, so do we detest ideational randomness. Therapists are too often faced with an overload of inchoate data that produce intolerable uncertainty: Any system that offers a parsimonious and easily comprehensible explanation for the bulk of the clinical data is very welcome —the closed system, for example, a tight psychoanalytic framework, or

transactional analysis, which offers an explanatory haven for all data, is manna indeed.

We have, I hope, come sufficiently far to lay bare many of the reasons behind the rich and varied plumage of the new group-therapy approaches.

One final point about certain common features of most of the new group approaches: they seem to me to be impregnated with impatience and they characteristically express a highly fractionated or non-holistic view of psychotherapeutic change.

I sense a pervasive impatience in many of the new approaches, impatience with traditional approaches, with delayed results, with subtle changes, with recycling and working through, and with cognitive, verbal approaches. Leaders look for, even demand, change *now.* Impatience shapes many of the newer techniques. Members are guided, beseeched, even coerced to "get in touch with their feelings." If affect is not present, it is provided by potent means of stimulation. Leaders incessantly search for the "breakthrough," that elusive will-of-the-wisp of the encounter groups; long-term credit is not extended, a sign of change is required at the moment—tears, a marked change in behavior or some outward evidence of a significant inner shift. Change is hoped for, not over months, but in a single day or weekend in the course of a single time-extended group meeting.

Fractionation is kin to impatience and both are offspring of a crash program, cost-accounting, technique-oriented mentality so peculiarly American. If self-disclosure is an integral part of the change process and is easily and quickly facilitated by group techniques, then an entire therapeutic approach—nude group therapy—is designed around an axis of disclosure both psychical and physical. The same holds for affect unblocking: If expression of anger is important, then why not a group therapy, like Synanon, in which the change process centers around rage release—indeed, one therapist refers to his approach as psychological karate. If people are alienated, out of touch, then why not foster a love group that endeavors to provide the quintessence of love and touching and closeness.

The cost is paid both by leader and participant. If the participant has come to believe that improvement is rapid, dramatic, and mediated via the breakthrough, then he will have cause to leave the group more discouraged than ever about achieving change. The therapist, if he is to avoid despair, will not permit himself full knowledge of the outcome of his efforts; instead he titrates his awareness of results by filtering his outcome observations. Lack of full success may beget such acceleration of vigorous healing efforts that he joins the ranks of such breakthrough revivalists as primal screamers, bioenergeticists or Rolfers.

Basic Foundations of Group Therapy

Although the torrent of technical innovations has swept away much of the formal edifice of group therapy, the basic theoretical foundations remain unchanged. If you believe, as I do, that there exists a finite and substantive set of mechanisms of change in psychotherapy, then it follows that technical approaches must be elaborated and understood against a horizon of these change mechanisms. Psychotherapy, precisely because it is a human experience, offers a rich array of opportunities for change, and the group-therapy experience, in particular, provides complex and varied therapeutic possibilities.

Perhaps we can best explicate the mechanisms of change in group therapy by first examining the more elemental question: why group therapy? There was a time when we might have answered the question in economic terms; after all if one therapist can treat seven or eight patients in ninety minutes, then why spend fifty minutes with one patient? The economic lure is a compelling one because our national mental-health needs demand that psychotherapists not only become more effective but more effective per unit of time.

Although economy may have been, in part, midwife to the group-therapy technique, the offspring has been an unruly one; group therapy is less a bargain than it seems. Most therapists prefer to work with a co-therapist, thus, in one step, halving the economic advantage. Groups are invariably more

emotionally demanding: it is the rare therapist who can lead more than one to two groups a day. There are limits upon the total number of patients, with accompanying names, histories, characterologic constellations, and demands, that a therapist can comfortably maintain in his *Lebensivelt.* Group therapy offers no substantial temporal advantages in that the total length of treatment in group therapy is no less than individual therapy. Although there are some therapists who have attempted brief group therapy on a crisis-intervention model, they have not demonstrated its efficacy and, for the most part, group therapy remains relatively long-term therapy.

Some have argued that the small group experience is so compelling and so intrinsically therapeutic that leaders require comparatively little training. This point of view issues from the erroneous equating of potency and effectiveness, to which I alluded above. It is true that groups will generally develop into systems that evoke powerful emotions; often it seems to me that only a particularly misguided leader can obstruct the development of many features of the intensive group experience. It is also true, however, that a powerful experience can be bivalenced: It can result in negative as well as positive therapeutic outcome. A recent study of encounter groups demonstrated an alarmingly high casualty rate: approximately 10 percent of college students who participated in an encounter group that lasted a total of thirty hours suffered some form of enduring negative psychological outcome. Group therapy, no less than any psychotherapeutic method, is not a do-it-

yourself endeavor; careful training is required and, unfortunately, the necessary training is too rarely available in traditional psychotherapy training centers.

No, it is not economy that affords an explanation: economic considerations provide neither the raison d'etre nor the theoretical underpinnings of group therapy. "Why group therapy" must be answered, not from the perspective of an inexpensive and diluted individual therapy but from the position that there are unique therapeutic opportunities inherent in the small group modality.

A theory of group therapy begins with the proposition that man is deeply embedded in an interpersonal matrix: he is first socialized in his primary family group, then in his elementary peer group, and eventually in a interpersonal megasociety. He is surrounded by other individuals who hear him, see him, and relay back to him their impressions of him; eventually, he must learn to befriend, to love, to fear, to understand, and to gain the approval of others. From within he is to a large extent constituted by the reflected appraisals of others; his sense of personal worth has been shaped from the perceived approval of others. Internally he will eternally interact with the introjected phantoms of the significant early figures in his life.

I do not imply that man is nothing but an interpersonal being; he is also

alone, and, to some extent, must live and certainly die alone; not only is he a being who is treated and shaped by others in accordance with established principles of learning theory, but he is also a constituting ego, creating a highly personal and never entirely predictable experiential world. However, even given those aspects which transcend man's interpersonal nature, few will quarrel with the heuristic value of conceptualizing personality theory and therapy as an interpersonal process.

When the group therapist operates out of the interpersonal position, he views every individual who seeks professional psychotherapeutic help as having an underlying and fundamental, interpersonal problem: an inability to establish or to maintain fully gratifying interpersonal relationships. The problem often manifests itself explicitly as patients describe their shattered relationship with a spouse, or their general alienation from others, their fears of the opposite sex, or their inability to be assertive. Sometimes the therapist must interpolate: the patient describes his dilemma as a problem in his relationship to a thing or a situation, for example, a phobia of driving, a depression, gastric distress, test anxiety. In each instance the therapist, in his early sessions with the prospective group patient, must lay bare the interpersonal "meaning" of his problem with a thing: the patient who feared driving "really" was expressing his distrust of others and even more his rage toward others as he experienced a compelling and murderous desire to collide with another car; the depressed person was in despair over the loss of

another; the gastric disorder represented anger and frustration toward others in an individual whose other affective expressive channels were blocked; the test anxiety reflected both the need and the fear of a vindictive triumph over others. Thus, in each instance, the therapist translated the thing or situation conflict into an interpersonal issue. The patients will do the same, for, as time elapses in the group, they reveal in their relationships with the other members their anger, mistrust, frustrations, inhibitions, morbid dependency, and conflicting feelings toward competition.

At the risk of belaboring the issue, I wish to emphasize that we must put quotes around "meaning" of symptoms, or what is "really" the source of the patient's problems. We can never really know the primordial, the true explanation for psychopathology. We can, however, formulate hypotheses assumptively and then gauge the explanatory power of the hypothesis and the efficacy of its practical application. The obfuscation, the reductionism, and the sectarian warfare occur when we forget the assumptive basis of the formulation and begin to regard such entities as ego, superego and id, parent, child and adult, animus, and anima as archetypes, and masculine protests as concrete entities rather than what they are: concepts, created for our intellectual and semantic convenience, that allow us to order data in a ready way and to formulate coherent approaches to therapy. Nor do I regard these constructs as expendable; some organizing system is essential for every therapist, lest he sink into the despair of perpetual uncertainty and nihilism.

Thus, the ideological frame of reference conceals, yet makes possible the successful therapeutic experience.

Once we have resolved that the interpersonal frame of reference is a viable approach and that, as Sullivan put it: “Psychiatry is the study of processes that involve or go on between people” and that “one achieves mental health to the extent that one becomes aware of one’s interpersonal relationships,” then we can appreciate the fact that the small group is an ideal vehicle of change. Few other situations offer such an arena for the display and correction of interpersonal pathology.

Thus, I choose to answer the question “Why Group Therapy?” by pointing out that the small group provides the logical clinical application of the interpersonal theory of personality development and psychopathology. One uses the therapy group most effectively to the extent that one maximizes the opportunities for interpersonal learning in small groups.

But let us be more specific: the group permits, first, a display and then a correction of interpersonal pathology. The display of pathology is a naturally unfolding process; a group with relatively few structural restrictions will ultimately develop into a social microcosm of the participant members. An individual who is, for example, vain or selfish or obsequious or exploitative or distant or controlling or disdainful in his relationships with the individuals in

his social environment will eventually demonstrate those very traits in his relationship to the members and the leader of the group. Sometimes this behavior is immediately apparent: an extremely narcissistic or dependent or arrogant individual may blatantly manifest these traits in his first interactions with the group members. Sometimes the interpersonal behavior pattern takes months to unfold; for example, as in the case of an individual who subtly seduces and then exploits others or who gains the confidence of another only as a preliminary stage in a campaign to defeat him or, in the case of another, who ostensibly seeks closeness only, ultimately, to flee from it. One of the major tasks of clinical group-therapy training is to enable the therapist to recognize these maladaptive interpersonal patterns.

A necessary condition for the display of interpersonal pathology is a focus on the "here-and-now." The here-and-now has two parameters: a basic ahistoric approach and an alternating pattern of de-reflection and self-reflection. The ahistoric approach in group therapy is merely a position assumed toward the question of evidence. It argues that no more valid data exist than the actual behavior of an individual in the group. There is little need for a patient to describe the past history of his disordered interpersonal relationships since he will, unwittingly, display it with great accuracy in the present tense of the group.

De-reflection and self-reflection refer to the alternating sequence of, on

the one hand, spontaneous unselfconscious interaction that must occur in the group if it is to be a vital experience and, on the other hand, a "stopping the action," a purposeful, intermittent reflection about behavior that has transpired so recently that, like a "ghost" on a television screen, it is still in the room.

The here-and-now has many fringe benefits, chiefly those of increasing the affect level of the group and sustaining the interest of all the members. The more members discuss issues of common interest, the more centripetal force is generated drawing them into the center of the group. Conversely, the more members discuss the then-and-there material from their historical past or from current interactions with individuals outside the group, the more uninvolved and unhelpful other patients will feel.

When sufficient displays of behavior have occurred that therapists and patients (generally, but not always, in that order) recognize as important and recurrent maladaptive interpersonal patterns, then the explicit process of correction begins. (The *implicit* process of correction begins at the very first meeting in a variety of indirect ways we shall discuss shortly.) The patient gradually becomes aware of his interaction through a feedback process in which the therapists and other members inform him of his behavior. This is a multifaceted process, as the others not only inform him of his blind areas (aspects of himself visible to others but not to self) but also of their reaction

to his behavior. It is one thing to learn, for example, that others see you as arrogant and judgmental; it is another thing to learn that this causes others to feel insecure and distrustful and thus precludes their developing a close, warm relationship with you.

Awareness of one's own behavior is not a step-wise procedure but a spiral one, in which the individual circles about himself repeatedly and first rejects, then partially accepts, and then fully integrates the feedback of the other members. Even then many raise the issue of relevance: for example, they may question the relevance of their interpersonal behavior for the problems that brought them to therapy or they may question the importance to them of the opinion of a group of strangers. If the group has developed an optimal level of cohesiveness and if the leader has been lucid in his interpolation of symptom into interpersonal pathology, then the issue of relevance may be dealt with as the resistance it represents.

Many other complex issues are involved in the change process, most of them far beyond the scope of this essay. One crucial, and core, constellation is "Do I wish to?" "Do I dare to?" "Can I?"

Many have invested much of their behavior with considerable pride: they are proud of being above others, or of being always right, or of being beloved by all, or of being beyond or impervious to the needs or wishes of

others. Much of the hard work of therapy consists in helping individuals realize the full implications, for themselves and for others, of their behavior. Only when one fully appreciates the primary dysphoria resulting from self-destructive behavior or the secondary dysphoria that is a reaction to the pain, withdrawal, or disapproval experienced by others in response to one's behavior, can one seriously confront the question "do I want to be like that?" "do I want to affect myself and others in this way?"

For many individuals maladaptive behavior is, nonetheless, better than some fantasied calamity that would ensue were they to behave differently. Though the feared calamity is often unconscious, it may be a ruthless tyrant dictating one's behavior. If, for example, at some level of awareness an individual fears that, were he to open the gates of his aggressive feelings, he might commit murder or were he to allow himself to experience his needs for tenderness, he would either be rejected or engulfed, then he would bury the possibility of the feared calamity by, in the first instance, ever-vigilant politeness and considerateness, in the second, by a communicated aloofness and freedom from needing others to touch him. The group helps such an individual "dare to" by encouraging or permitting risk taking, by helping him sample, ever so faintly, the feelings and behavior he has so assiduously and for so long eschewed. After repeated daring to, in the presence of others who matter to him and without the occurrence of the feared consequences, the behavior and attitudinal change become enduring. The process may be

abetted by interpretation, by the individual's conscious awareness of the heretofore unconscious conflict, but there is reason to believe that the behavior change may occur even in the absence of such insight.

"Can I" is inextricably interwoven into the psychotherapeutic process and brings us face to face with the unspeakable paradox in psychoanalytic theory: that the process of therapy brings the patient to the point where he can make a choice in his own best interests and yet at the same time he is, from the very first, totally determined. In group therapy, we take the best from both worlds: determinism is transformed into "understanding" and "I can't" into "I won't." By fully knowing the developmental and the current dynamic roots of an individual's behavior, even the most offensive presentation of self can be understood and, as Montaigne reminded us four centuries ago, to understand all is to forgive all. In the group, forgiveness, or a non-judgmental acceptance, makes it possible for individuals to interact in novel ways without the vicious spiral of offensive behavior and resultant rejection that ignites further defensive-offensive behavior. Acceptance in a therapy group is never forever; people are accepted, behavior is criticized. The global, intellectualized "Can I change?" dissolves in the unending group stream of small but meaningful changes observable in each of the group members.

To summarize, small groups offer an excellent treatment vehicle

because they allow the display and correction of specific maladaptive interpersonal behavior. They offer, in addition, a number of avenues for change. For example, the experience of belonging to and being valued by a group is, for many individuals, a significant ameliorative life event. Many troubled individuals have a lifelong history of group deprivation: the stable nuclear family, the extended kinship unit, the childhood peer group, adolescent social cliques, athletic teams, neighborhood groups, dating courtship circles—all have passed them by. For these individuals the sheer experience of being accepted and valued members of a group may, even in the absence of cognitive gains, powerfully affect their self-acceptance and their sense of personal worth.

The amount of attraction to the group shared by all the members is often referred to as cohesiveness and is the group-therapy analogue of "relationship" in individual therapy. Little effective work can be done in its absence. Groups with low cohesiveness will have less trust, less self-disclosure, poor attendance, and, eventually, poorer outcome. Members with low attraction to the group, even measured early in the course of the group by a simple paper and pencil questionnaire, have little likelihood of achieving positive gain.

An individual's self-esteem is closely related to his perception of his public esteem; to a significant degree, he remains concerned and influenced

by the evaluation given him by groups to which he belongs. How much the group influences self-esteem is dependent on several factors: the stability of his own sense of worth, the importance of the group to him; the specificity, frequency, and saliency of the group's communications that bear on his self-esteem. Most individuals seeking psychotherapeutic help have considerable difficulty in maintaining their sense of self-worth; many experience their self-esteem as a bobbing balloon, prey to the winds of others' judgments. If an individual repeatedly experiences a discrepancy between his sense of personal worth and the group's various appraisals of him, then eventually he must resolve this dissonance. If, for example, the group values him more highly than he values himself, he might question the value of this group or their basis for judgment. He might think, "If they only knew" or reinterpret the group's comments to his disadvantage. In a well-integrated therapy group the individual values the judgments of the other members. He has been through a great deal with them, their feedback to him is explicit, and he can scarcely question their basis for knowing him since he has often revealed himself more fully to them than to any other group of individuals. Unlike the actor who can dismiss the audience's applause by assuming that it is not for him but for his role, the group-therapy patient must come to a different conclusion since he has, throughout, been encouraged to doff his customary role. He cannot question the importance of the traits under discussion since the group so often deals with core-identity issues. If he attempts to convince

the group of his unworthiness by revealing more of his shameful dark areas, a curious paradox unfolds: since members are rewarded in a group for their adherence to group norms, and disclosure of inadequacies is a cherished therapy group norm, the more he reveals, the more he is ultimately respected. Eventually a therapeutic shift may occur, as he reevaluates the veracity and basis of his myth of personal worthlessness.

There is research support for this sequence of events. Social psychologists have convincingly demonstrated that group consensus can exert sufficiently strong pressure to cause individual distortions in visual perceptions of material objects. The same force can be harnessed to encourage attitudinal shifts. Group-therapy patients who, early in the group, are deemed, on sociometric measures, to be more popular (by dint of their active participation in the group tasks) are those destined to profit most from the therapy. Encounter-group members who are active and considered by the other members as highly influential early in the group will eventually experience the highest rates of personal growth. As the group comes to value an individual, so, too, does he come to value himself.

In addition to the opportunities for the explicit display and correction of maladaptive interpersonal behavior and the benefits accruing from group cohesiveness, there are a number of other potential mechanisms of change relatively specific to the group-therapy format. No doubt, these will continue

to be an intrinsic part of the group-therapeutic process, whatever changes in outward form the future brings.

Universality operates as a change mechanism in the great majority of therapy groups. Patients often enter the group with the deep conviction that they are unique in their wretchedness. Not uncommonly they have had little opportunity for candid reciprocal sharing with another individual, and, furthermore, often because of an unusual constellation of life stresses, they are besieged by unusual or frightening fantasies or by recollections of past experiences. For many group members the disconfirmation of their sense of uniqueness is a great relief. Early in the group they not only hear other members disclose concerns, fantasies, and life experiences closely paralleling their own, but they also have the opportunity to reveal themselves and be, nonetheless, accepted and approved by others. Simply put, they experience a sense of being "welcome to the human race," which, though present to some degree in individual therapy, is more powerfully built into the group format. Patients can be grateful for the therapist's acceptance, but nonetheless can ascribe it to his professionalism. They cannot so easily dismiss the other members who are neither trained nor paid to listen, accept, or reveal themselves.

Opportunities for *altruistic behavior* often present themselves in therapy groups. Members may give to others in a variety of ways: they give

time, their "share" of the group attention, support, advice, and, above all, care. At the end of a group-therapy experience patients often, in their reminiscences about the group, recall the helpful interventions of the other members more vividly than those of the therapist. Indeed, the experienced group therapist learns to sit on his wisdom in the awareness that patients more often accept interpretations from other members than from the therapist. Many patients enter therapy morbidly self-absorbed, so demoralized that they are convinced they have little of value to offer; they may have long experienced themselves as parasitic burdens to others, and it is refreshing, even exhilarating, to find that they can be of significant help to others. Altruistic de-reflection is a venerable concept in the healing tradition; as exemplified by the shaman who since prehistory have prescribed for patients the task of preparing a tribal feast or performing other services to the community.

Groups wield powerful suggestive force and in the substratum of the group there is a subtle but persistent *instillation of hope.* The establishment and maintenance of faith in therapy is crucial to all psychotherapies; amulets, drumbeats, testimonials, impressive diplomas, erudite formulations, and prescriptions in Latin are all dedicated to that end. The therapy group invariably contains individuals in differing stages of coping with major problems. Members see or hear about others who have improved in the group. They also encounter people who have dealt, and, to some extent,

overcome problems very similar to their own. Some groups, for example, Alcoholics Anonymous or Recovery Incorporated, explicitly build into their ritual the testimony of the improved patient. In other groups the process is subtler, the therapist implicitly encouraging patients to recount their improvement and the members themselves gratuitously proffering testimonials to buoy up the hopes of a demoralized, unconvinced patient.

Spectator therapy, a deliberate and explicit behavioral approach to phobia desensitization, is an omnipresent but more implicit adjunct to learning in group therapy. It is common for members to benefit vicariously from observing others with problems similar to their own, working in ways not yet possible for them. Members of therapy groups have a wide exposure to a "number of problem-solving strategies and, through a conscious or preconscious imitative process, may try on, for size as it were, various modes of approaching important dilemmas. Even if imitative behavior is short-lived it may function to “unfreeze” the individual as he experiments with new kinds of behavior.

Although I have offered but a sketch of the opportunities for change available in group therapy, we may appreciate the waste, the unfulfilled potential of group-therapy approaches that fail to harness the interpersonal and social-field forces inherent in the small group. Fractional approaches abound. Some therapists do individual therapy in a group; others magnify

such part processes as self-disclosure or mutuality or the intensification of affect or desensitization to social anxiety, but no fractional approach constitutes a balanced group therapy that uses a full orchestration of the medium.

In retrospect, what have we said about the future of group therapy? That it is to a large extent currently in a non-self-reflective, flamboyant stage, propelled by many factors but chiefly by an over-cathexis to technique. The preoccupation with technique stems from an activistic, optimistic, basically pragmatic approach to individual and social change. However, technique spawned from technique is ultimately destined to cave in upon itself. What is needed is a fuller appreciation and reconsideration of the theoretical assumptions upon which all technique must stand.

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